HIPPA ACKNOWLEDGEMENT AND CONSENT FORM

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up care among multiple healthcare providers who may be involved in treatment directly or indirectly.
- Obtain payment from designated third-party payers
- Conduct normal health care operations such as quality assessments or evaluations and physician certifications.

I have been informed by Korth Pain & Sports Rehabilitation of your *Privacy Policy Statement* containing a more complete description of the uses and disclosures of my health information. I have reviewed the *Privacy Policy Statement* prior to signing this consent and acknowledge that I have studied the *Privacy Policy Statement* prior to signing this consent. I understand that this organization has the right to change its *Privacy Policy Statement* from time to time and that I may contact this organization at any time to obtain the current copy of the *Privacy Policy Statement.*

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand the organization is not required to agree to my requested restrictions but if the organization does agree, then it is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, excepts to the extent that the organization has taken action relying on this consent.

_____

Patient's Name (Printed) Date of Birth

_____

Signature of Patient or Legal Representative for Patient Date

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Legal Representative's Relationship to Patient