

Scott Gynecology & Pelvic Surgery, PC
770-405-0391

HIPAA Consent Form

I understand that I have some rights regarding my IIIHI (Individually Identifiable Health Information), given to me by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). By signing this patient consent, I hereby authorize Scott Gynecology & Pelvic Surgery, PC to use and disclose my health information for the following purposes:

- Treatments: Including other healthcare providers involved in my treatment.
- Payments: To obtain payments from any third party (including my insurer).
- Healthcare operations: Day-to-day healthcare operations at your clinic.

I have been given the right to inspect a copy of your Patient Privacy Policy, which details the use and disclosure of my health information and my rights regarding it. I understand that Scott Gynecology & Pelvic Surgery, PC reserves the right to amend these policies from time to time and I can ask for a copy of the current policy statement anytime.

I also understand my rights to request restrictions on how you use and disclose my IIIHI for various purposes, but you are not required to agree to my request. However, if you do agree, then you have to follow it.

I understand that I have the right to revoke this consent anytime, in writing. However, the use and disclosure of my IIIHI that occurred prior to the date I revoke will not be affected.

Date:

Patient Name: _____

Relationship to Patient (if minor or guardian): _____

Signature: _____