Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

PATIENT NAME **DATE**

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Bay Area Chest Physicians may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Bay Area Chest Physicians has a detailed document called the **'Notice of Privacy Practices'**. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the *'Notice'* before signing this agreement. If I ask, Bay Area Chest Physicians will provide me with the most current *Notice of Privacy Practices*.

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices*. My signature means that I agree to allow Bay Area Chest Physicians to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Bay Area Chest Physicians has taken action relying on this consent.

SIGNATURE (Patient or Legal Custodian/Authorized Representative) **DATE**

Relationship to Patient if signed by another party **DATE**

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our 'Notice' at any time by contacting: Bay Area Chest Physicians 430 Morton Plant St Suite 405 Clearwater, FL 33756 Attn: HIPAA Representative.

FORM Us