

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 Dr. John C. Robinson 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.

Dr. John C. Robinson 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, Dr. John C. Robinson 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 Dr. John C. Robinson 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 Dr. John C. Robinson 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: Michelle Celli , Office Manager 707-537-1002 or jcrobinsdds@gmail.com.

FORM Us