



**Patient Consent and
Health Insurance Portability and Accountability Act
(HIPAA)**

Patient Name: _____

Date of Birth: _____

Consent for use and disclosure of protected health care information as required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

You have the right to review the Notice of Privacy Practices and have been given the opportunity to review that document before signing this consent. You have also been made aware that you have the right to request a written copy for the office's Notice of Privacy Practices and that this office, Audiology and Hearing Aid Center of Gainesville, reserves the right to revise its Notice of Privacy Practices at any time. You will be given a copy of the revised notice with your first office visit following any change.

Signature of Patient or personal representative

Date

Relationship of personal representative to patient