Complete Health Services
831 University Blvd. East, #36A
Silver Spring, MD 20903

PATIENT CONSENT FORM

Our Notice of Privacy Practice provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our notice before signing this consent. The term of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how to protect health information about you is used or disclosed for treatment payment or health care operations. We are not required to agree to this restriction but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent in writing, signed by you. However a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Patient Understands That:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practice and the patient has this opportunity to review this notice.
- The Practice reserves the right to change the Notice of Privacy Policies does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this consent.

This Consent was signed by _____

Patient Signature or representative (state relationship)

Witness _____ **Date** _____

Practice Representative