Hedi L. Leistner, MD PLLC

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Patient Consent Form

I understand that under the Health Portability & Accountability Act of 1996 (HIPPA) I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been given by you your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization as a right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time except to the extent that you have already acted relying on this consent.

Patient Name: _____ _____ Date: _____

Signature: _____

Guarantor's Name: _____ Relationship: _____