CUMBERLAND FAMILY PRACTICE

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Patient HIPAA consent for physicians to use or disclose health care information for treatment, payment, and health care operations.

PATIENT NAME: _____ **DOB:** _____

To give consent to disclose health information to someone **OTHER than the patient**, please write their name below: (e.g. spouse, parent, caretaker, family member, etc.)

DESIGNATED PERSONS: _____

I understand that my health information is private and confidential. I understand that **Cumberland Family Practice** works very hard to protect my privacy and the confidentiality of my personal health information.

I understand that signing this document meant that **Cumberland Family Practice** may use and disclose my personal health information to help provide health care to me, to handle billing and payment, and to take care of other health operations. Failure to sign this consent may result in the physician declining to treat me.

Under the terms of this consent, I can ask **Cumberland Family Practice** to restrict how my personal health information is used or disclosed to carry out treatment, payment, or health care operations. I understand that **Cumberland Family Practice** does not have to agree to my request. If they do agree, I understand that they will follow the agreed upon limits.

I understand that I have the right to cancel this consent in writing at any time. If I do cancel this consent, I understand that **Cumberland Family Practice** may have already used and disclosed information and me and canceling this consent would not affect the information already used or disclosed.

I may cancel this consent by doing the following: Writing, signing, and dating a letter to **Cumberland Family Practice** that says I want to revoke my consent authorizing the use of my personal health information.

I understand that if I cancel this consent, **Cumberland Family Practice** is not obligated to provide further health care services for me.

_____ _____

PATIENT OR LEGALLY AUTHORIZED REPRESENTATIVE'S SIGNATURE **DATE**