Uvalde Family Practice Assn.
1800 Garner Field Road • Uvalde, TX 78801 • PH (830) 278-4453 • FAX (830) 278-3427

Patient Consent for HIPAA

I understand that I/the patient have certain rights to privacy regarding my/the patient's protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my/the patient's protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my/the patient's protected health information and my/the patient's rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I/the patient have the right to request restrictions on how my/the patient's protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

Patient Consent for Treatment

I voluntarily consent to any and all health care treatment and diagnostic procedures provided by Uvalde Family Practice Association and its associated physicians, clinicians and other personnel. I am aware that the practice of medicine and other health care professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations at Uvalde Family Practice Association.

I authorize payment of medical benefits to Uvalde Family Practice Association physicians or their designee for services rendered.

I give permission to obtain all my medication/prescription history when using an electronic system to process prescriptions for my medical treatment.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Patient Name (printed): _____

Patient/Guardian Name (signature): _____

☐Self ☐Relationship to Patient _____