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HIPAA CONSENT FORM

I consent to the use or disclosure of mu protected health information by **Dr. Amy S. Dunetz** for the purpose of diagnosing or providing treatment to me, obtaining payment for health care bills or to conduct health care operations of **Dr. Amy S. Dunetz**. I understand that diagnosis and treatment of me by **Dr. Amy S. Dunetz** may be conditioned upon consent as evidenced by my signature on this document.

I understand I have the right to request restrictions as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **Dr. Amy S. Dunetz** is not required to agree to the restrictions I may request. However, if, **Dr. Amy S. Dunetz** agrees to a restriction that I request, the restriction is binding on **Dr. Amy S. Dunetz**.

I have the right to revoke the consent, in writing, at any time, expect to the extent of **Dr. Amy S. Dunetz** has taken action in reliance on this consent.

My "protected health information" means health information including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a health care clearinghouse. This protected health information related to my past, present or future physical or mental health condition and identifies me, or there is a reasonable bias to believe the information may identify me.

I understand I have the right to review **Dr. Amy S. Dunetz,** Notice of Privacy Practices prior to signing this document and this has been provided to me. The Notice of Privacy Practices describes the types of used and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of **Dr. Amy S. Dunetz.** This Notice of Privacy Practices also describes my rights and duties with respect to my protected health information.

Dr. Amy S Dunetz reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices.

_____ _____

Patient Name (Please Print) Date

_____

Parent, Guardian or Patient's legal representative

_____

Signature