Amandeep Pal M.D. PLLC

PATIENT CONSENT FORM

I Understand that, under the Health Insurance 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 multiple healthcare providers who may be involved in that treatment directly and in directly.
- Obtain payment from third- payer parties.
- Conduct normal healthcare operations such as quality assessments and physician certifications.
-

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing the consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time 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 do 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 taken action relying in this consent.

I understand you may release my PMI to:
1:Name_____ relationship _____phone#_____
2: Name _____relationship_____phone#_____

I wish to be contacted in the following manor: (check any or all)
Home/ Voice mail_____ cell/voice mail _____ work/voice mail_____

Patient Name _____
Signature_____ Date: _____

Relationship to Patient _____
(Self, parent, other)