Shekinah
HEALTH & WELLNESS CENTER

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified on your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The patient has the right to request restrictions on how their PHI is used and disclosed to carry out treatment, payment and health care procedures.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

1. May we phone, email, or send a text to you to confirm appointments? Yes ☐ No ☐
2. May we leave a message on your answering machine at home or on your cell phone? Yes ☐ No ☐
3. May we discuss your medical condition with any member of your family? Yes ☐ No ☐

If YES, please provide family member's name (s)

Name		
Relationship		
Address		
Phone #		

Disclose additional health information related to:

Mental Health Yes No

Communicable Diseases (HIV/AIDS) Yes No

Alcohol/Substance Abuse Yes No

This consent was signed by: _____ (PRINT NAME)

Signature: _____Date: _____

Witness: _____Date: _____