Client HIPAA Consent and Acknowledgment Form

Practice/Organization Name: _____
Provider Name: _____
Office Phone: _____
Office Email: _____
Office Address: _____
City/State/ZIP: _____

##Client Information

Client Full Name: _____
Date of Birth: _____ **Age:** _____
Phone Number: _____
Email Address: _____
Mailing Address: _____
City/State/ZIP: _____
Emergency Contact Name: _____
Emergency Contact Phone: _____
Relationship to Client: _____

Notice of Privacy Practices Acknowledgment

The client acknowledges receipt of, access to, or the opportunity to review the Notice of Privacy Practices for _____. This notice explains how protected health information may be used, shared, maintained, and protected, as well as the privacy rights available regarding health information.

Protected health information may include identifying, medical, mental health, billing, insurance, appointment, treatment, and communication records maintained by the practice or organization.

Client Initials: _____

Consent for Use and Disclosure of Protected Health Information

The client authorizes _____ to use and disclose protected health information for purposes related to treatment, payment, and health care operations. These purposes may include coordination of care, appointment scheduling, billing, insurance processing, documentation, referrals, consultation with other providers involved in care, administrative operations, and other activities permitted by applicable privacy regulations.

Information may be shared only as allowed by law, required by law, or authorized in writing by the client or legally authorized representative.

Client Initials: _____

Client Rights Acknowledgment

The client acknowledges understanding of the following privacy rights regarding protected health information:

-Right to request access to health records
-Right to request a copy of health records
-Right to request corrections or amendments to health records
-Right to request restrictions on certain uses or disclosures
-Right to request confidential communication methods
-Right to receive an accounting of certain disclosures
-Right to receive a paper or electronic copy of the Notice of Privacy Practices
-Right to revoke authorization in writing, except when action has already been taken based on prior authorization

Client Initials: _____

Communication Preferences

Preferred communication methods may be selected below. Communication through email, text message, voicemail, or other electronic methods may involve privacy risks.

Communication Method	Permission Granted	Notes/Restrictions
Phone call	[ ] Yes [ ] No	_____
Voicemail	[ ] Yes [ ] No	_____
Text message	[ ] Yes [ ] No	_____
Email	[ ] Yes [ ] No	_____
Patient portal/secure messaging	[ ] Yes [ ] No	_____
Mail	[ ] Yes [ ] No	_____

Preferred Phone Number: _____
Preferred Email Address: _____
Preferred Mailing Address: _____

Voicemail and Message Authorization

The practice or organization may leave messages related to appointments, scheduling, billing, or care coordination according to the selections below.

[ ] Detailed messages may be left
[ ] Appointment reminders only may be left
[ ] Billing-related messages may be left

[ ] No voicemail messages may be left
[ ] Other instructions: _____

Client Initials: _____

Authorization to Share Information with Designated Persons

The client authorizes the following individuals to receive information related to care, appointments, scheduling, billing, or other approved matters as indicated.

Name	Relationship	Phone Number	Information Allowed
_____	_____	_____	[ ] Care [ ] Appointments [ ] Billing [ ] Other: _____
_____	_____	_____	[ ] Care [ ] Appointments [ ] Billing [ ] Other: _____
_____	_____	_____	[ ] Care [ ] Appointments [ ] Billing [ ] Other: _____

Restrictions or Special Instructions:

##Release of Information to Other Providers or Agencies

The client authorizes communication with other providers, agencies, or professionals involved in care as needed for treatment coordination, referrals, documentation, continuity of care, or related services.

[ ] Authorization granted
[ ] Authorization not granted
[ ] Authorization limited as follows: _____

Provider/Agency Name: _____
Phone/Fax/Email: _____
Purpose of Communication: _____
Information Authorized for Release: _____

Revocation of Consent

This consent may be revoked in writing at any time, except to the extent that action has already been taken based on this consent. Written revocation must be submitted to _____.

Client Initials: _____

Client Certification and Signature

By signing below, the client or legally authorized representative confirms that this form has been reviewed, understood, and completed accurately. The signature also confirms acknowledgment of the Notice of Privacy Practices and consent for the use and disclosure of protected health information as described in this form.

Client Signature: _____
Printed Name: _____
Date: _____

Legal Representative Information

Complete this section only if the form is signed by a parent, guardian, health care proxy, power of attorney, or other legally authorized representative.

Representative Full Name: _____
Relationship/Authority: _____
Phone Number: _____
Email Address: _____
Representative Signature: _____
Date: _____

For Office Use Only

Form Received By: _____
Date Received: _____
Notice of Privacy Practices Provided: [ ] Yes [ ] No
Copy Provided to Client: [ ] Yes [ ] No
Entered into Client Record By: _____
Date Entered: _____
Additional Notes: