Dr. Nancy J. Duggan
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(301) 249 1102

Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), 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 the multiple healthcare providers who may be involve in that treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Patient Privacy,* which contains a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Patient Privacy* prior to signing this consent. I understand that this organization has the right to change its *Notice of Patient Privacy* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Patient Privacy.*

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 healthcare operations. I also understand you are not required to agree to any requested restrictions, but if you do agree to them 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 relying on this consent.

I authorize you to view my prescription history from external sources in order to facilitate appropriate medication orders and reconciliation.

Printed Name: _____

Signature:_____

Relationship to patient: Self / Spouse / Parent / Child / Guardian- POA

Date: _____

Please write the name(s) of person(s) authorized to discuss your protected health information:

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