Suwanee Family Physicians
960 Peachtree Industrial Blvd.
Suwanee, GA 30024

Health Information Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent form I authorize you to use and disclose my protected health information to carry out:

- Treatment including direct and indirect treatment by other healthcare providers involved in my treatment.
- Payment from third party payers ie. my insurance company.
- The day-to day operation of this practice.

I have also been informed of and given the right to review and secure a copy of our Notice of Privacy Practices.

I understand I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these restrictions. However, if you do agree, you are then bound to comply with these restrictions.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name:_____

Relationship to Patient: (Self, Spouse, Parent, Other)_____

Signature: _____ Date: _____/_____/_____