Daniel Island Family Care
Dr. Melissa Hunter
HIPPA Notice of Privacy

Purpose of Consent: by signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.
HIPPA Notice of Privacy Practices: our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.
We reserve the right to change our privacy practices as described in our HIPPA Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.
You may obtain a copy of our HIPPA Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting our office.
Right to Revoke: you have the right to revoke this consent at any time by giving us written notice. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.
Authorized Contact Persons: there are times that we need to speak with family members or significant others about your medical care. Please list those persons, relation, and phone number which take an active part in your healthcare

Name:_____ Relation:_____

Phone:_____

Name:_____ Relation:_____

Phone:_____

I, _____, have had full opportunity to read and consider the contents of this Consent form and the HIPPA Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations. I have received the Notice of Privacy Policy and I have been provided an opportunity to review it

Name:_____
Date:_____
Signature:_____

If this Consent is signed by a personal representative on behalf of the patient, please complete the following:
Personal Representative's Name: _____
Relationship to the Patient: _____
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