



## **Health Insurance Portability and Accountability Act (HIPPA) Consent Form**

### **Consent for Purposes of Treatment, Payment, and Healthcare Operations**

I consent to the use or disclosure of my protected health information by Magic Valley Pain Specialists for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Magic Valley Pain Specialists. I understand that diagnosis or treatment of me by Magic Valley Pain Specialists may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. Magic Valley Pain Specialists is not required to agree to the restrictions that I may request. However, if Magic Valley Pain Specialists agrees to a restriction that I request, the restriction is binding on Magic Valley Pain Specialists.

I have the right to revoke this consent, in writing, at any time, except to the extent that Magic Valley Pain Specialists has acted in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me, and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Magic Valley Pain Specialists' Notice of Privacy Practices prior to signing this document. Magic Valley Pain Specialists' Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations of Magic Valley Pain Specialists. The Notice of Privacy Practices for Magic Valley Pain Specialists is also provided in the facility office. This Notice of Privacy Practices also describes my rights and Magic Valley Pain Specialists' duties with respect to my protected health information.

Magic Valley Pain Specialists reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by call Magic Valley Pain Specialists and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

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Signature of Patient or Personal Representative

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Name of Patient or Personal Representative

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Date