Holly Kay Wyneski, M.D.

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Wooster, Ohio 44691

HIPAA PATIENT CONSENT FORM

Our office of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review or Notice before signing the consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information (PHI) about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information (PHI) about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice Has A Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the use of their information, but the Practice does not have to agree with those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.
- The patient acknowledges that she has received a copy of our HIPAA practices.

This Consent was signed by: ____

Printed Name/Date: ____

Relationship to patient: ____

This consent was refused by: ____

Printed Name/ Date: ____

Relationship to patient: ____

Witness: ____ Date: ________________

Printed Name/Practice Representative: Sherry Geiser (Administrative Secretary)

May we leave a message at your home with other residents? ___Yes ___No

If you have an answering machine or voicemail, may we leave a message? ___ Yes ___ No

Who may we talk to about your medical concerns: ____________________________________

Relationship: ____________ Phone num: Cell phone________________ Home:____________

If you want your mail sent to alternate address:

____