Joseph J. Cipriano,D.C.

Buckhead Office• 3025 Maple Drive Suite 2 • Atlanta, GA 30305 • Ph 404.261.9522

Patient Consent for Use and Disclosure of Protected Health Information

This form is necessitated by HIPAA Federal Privacy Regulations. We apologize for the cost, time spent, and inconvenience caused by the administration of HIPAA rules.

I hereby give my consent for Joseph J. Cipriano, D.C.to use and disclose protected health information (P.H.I.) about me to carry out treatment, obtain payment, and perform healthcare operations (T.P.O.).

Joseph J. Cipriano, D.C. Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Atlanta Orthopedics reserves the right to revise its Notice of Privacy Practices at any time. A revised and current Notice of Privacy Practices may be obtained by forwarding a written request to:

Joseph J. Cipriano, D.C.
3025 Maple Drive Suite 2
Atlanta, GA30305

With this consent, Joseph J. Cipriano, D.C., may call my home or alternate locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out T.P.O., such as appointment reminders, insurance inquiries, and any call pertaining to my clinical care, including laboratory results among others.

With this consent, Joseph J. Cipriano, D.C., may mail to my home or alternate locations any items that assist the practice in carrying out T.P.O., such as appointment reminders and financial statements.

I have the right to request, in writing, that Joseph J. Cipriano, D.C., restrict how it uses my P.H.I. to carry out T.P.O. However, the practice is not required to agree to my requested restrictions, but if it does agree; it is bound by this agreement.

By signing this agreement, I am consenting to Joseph J. Cipriano, D.C.the use and disclosure of my P.H.I. to carry out T.P.O.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent or later revoke it, Joseph J. Cipriano, D.C., may decline to provide treatment to me.

THIS FORM MUST BE SIGNED BELOW. I have read and agree to the above:

PLEASE PRINT FULL NAME ____

SIGNATURE OF PATIENT (OR GUARDIAN) DATE SIGNED ______________

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