Diamond Headache Clinic
Treatment – and beyond

Notice for HIPAA Compliant Release and Use of Confidential Information and Access to Notice of Privacy Practices

Patient Name:	Date of Birth:	Phone Number:
Address:		

- I acknowledge that Diamond Headache Clinic will use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record.
- Additional explicit authorization for release of information may be required for disclosing medical information to third parties that are not affiliated with Diamond Headache Clinic.
- I have access to the Diamond Headache Clinic Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about now the practice may use and disclose my confidential information.
- I understand that the practice has reserved the right to change the Notice of Privacy Practices. I also understand that a current copy of the Notice of Privacy Practices is available upon request.
- I understand that this consent is valid until it is revoked by me. I may revoke this consent at any time with written notice of intent mailed to the practice. I may not be able to revoke consent in cases where the practice has already used or disclosed my health information.

Signature of Patient or Representative:	Date:
Name of Signer:	Relationship: