CONNECTICUT NEUROLOGICAL SPECIALIST LLC

HIPAA CONSENT FORM

455 Lewis Avenue, Suite 202
Meriden, CT 06451
Phone: 203-630-1000
Fax: 1-203-413-3333

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third parties.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

Connecticut Neurological Specialist has a Notice of Privacy Practices containing a more complete description of the uses and disclosures of protected health information about me. I have the right to review the Notice of Privacy Practices from Connecticut Neurological Specialist before signing this consent form. I understand that Connecticut Neurological Specialist has the right to change its Notice of Privacy Practices from time to time and that I may contact them at any time to obtain a current copy of the Notice of Privacy Practices.

Patient Name: _____ Signature: _____ Date: _____

If signed by legal representative, relationship to patient: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices, but was unable to do so as documented below:

_____ Patient Declined

_____ Emergency

_____ Other:

_____

Employee Name: _____ Signature: _____ Date: _____