HIPAA
Patient Consent Form

This notice provides information about our Privacy Practices and how we may use and disclose protected health information about you. Prior to signing this consent you have the right to review our Privacy Practices. Privacy Practices terms may change at any time. If the terms of Privacy Policy has changed you may obtain a copy by contacting our office at:

EverMed DPC
PO Box 453
Camas, WA 98607-0049

You may request that we restrict how your protected health information is used or disclosed for any treatment, payment or health care operations. Although we are not required to abide by this restriction, if we do, we may honor that agreement.

By signing this form, we are gaining your consent to our use and disclosure of Protected Health Information about you. This Information may include information for treatment, payment and health care operations. You may revoke this consent in writing, via a requestsigned by you. Any revocation shall not affect any disclosures we have already made with your prior consent. Our company provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The patient understand that:

- Information about my protected health information may be disclosed or used for treatment, health care operations or payment.
- The patient has had an opportunity to read and review our Notice of Privacy Practices.
- Information about the patient may be restricted but that the practice does not have to agree to the restriction
- Patient may revoke this consent at any time in writing for all future disclosures to cease

Signed By:

Printed Name:

Relationship to patient
(if other than patient)