HIPAA Compliance Patient Consent Form

Under our Notice of Privacy Practices, Jan Active Therapy, may utilize and disclose protected health information about you, in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The notice contains the patient's rights section describing your rights under the HIPAA law. You ascertain that by your signature you have reviewed our notice before signing this consent. If the terms change you will be notified at your next visit.

You retain the right to request limitations on the use or disclosure of your protected health information for treatment, payment, or health care operations. While we are not obligated to agree to your restrictions, if we do, we are bound by our agreement with you.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations
- The practice reserves the right to change the privacy policy as allowed by law
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease
- The practice may condition receipt of treatment upon execution of this consent

_____ **(Initial)** Yes, I consent to allow Jan Active Therapy's therapists and administrative staff to leave messages containing Protected Healthcare Information via phone, email or text.

_____ **(Initial)** Yes, I grant permission to use my email address to inform me of Jan Active Therapy notifications, including scheduling, invoices, news, and events. (Email addresses will not be shared with third parties.) I understand that email is not a secure form of communication.

_____ **(Initial)** No, I do not grant permission for Jan Active Therapy staff to leave messages that include Protected Healthcare information on my home, work, and cell phones.

May we discuss your medical condition with any member of your family? **YES / NO**

If YES, please name the members allowed: ______________________________________

Patient Name (Please Print): ______________________________

Patient Signature: ______________________________

Date: __________________________