PATIENT CONSENT FORM

ATWOOD FAMILY MEDICAL CENTER
CHESAPEAKE EXECUTIVE FAMILY CARE
108 KNELLS RIDGE BOULEVARD
SUITE 100
CHESAPEAKE, VA 23320

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-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by Atwood Family Medical Center (AFMC) of their *Notice of Privacy Practices*, which contain a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time, and that I may contact AFMC at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that AFMC restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand AFMC is not required to agree to my requested restrictions, but if AFMC does agree that AFMC is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that AFMC has taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____