

HIPPA Consent Form:

I give VIP Therapy LLC my consent to use my protect health information to carry out my treatment and for health care operations like quality review.

I have been informed that I may review VIP Therapy LLC Notice of Privacy Practices for a more complete description of uses before signing this consent.

I understand that VIP Therapy LLC has the right to change their privacy practice and that I may obtain any revised notices from VIP Therapy LLC.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that VIP Therapy LLC is not required to agree to the request. If VIP Therapy LLC agrees to my requested restrictions they must follow the restriction(s).

I also understand that I may revoke this consent at any time by making a request in writing, except for information already used or disclosed.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_