Patient HIPAA Consent Form
Behavioral Health Partners
6155 Oak Street, Suite E
Kansas City, MO 64113
www.behavioralhealthpartners.net

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1966 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day health operations of Behavioral Health Partners

I have also be informed and given the right to review and secure a copy of Behavioral Health Partner's *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosure of my protected health information and my rights under HIPAA. I understand that Behavioral Health Partners reserves the right to change the terms of this notice from time to time and that I may contact Behavioral Health Partners at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that Behavioral Health Partners is not required to agree to these requested restrictions. However, if Behavioral Health Partners does agree, Behavioral Health Partners is bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____ 20 _____.

Print Patient Name _____

Signature _____

Relationship to Patient _____