

- Patient First Name *

- Patient Last Name *

- Relationship to the patient *

- Name if not the patient *

- 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 care among the multiple healthcare providers who may be involved in that treatment directly or indirectly

-Obtain payment from designated third-party payers.

-Conduct normal health care operations such as quality assessments or evaluations, and physician certifications.

- I have been informed by you of your Notice of Privacy Practices that contains a more complete description of the uses and disclosures of my health information (available at the following link [HIPAA Notice of Privacy Practices](#) or in office in print form).

I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that Pedro Steven Buarque de Macedo, MD has the right to change its Notice of Privacy Practices from time to time and that I may contact Pedro Steven Buarque de Macedo, MD at any time to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that Pedro Steven Buarque de Macedo, MD restricts how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand Pedro Steven Buarque de Macedo, MD is not required to agree to my requested restrictions, but if Pedro Steven Buarque de Macedo, MD does agree, then it 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 Pedro Steven Buarque de Macedo, MD has taken action relying on this consent.

- By checking the box I acknowledge that *

- I received and read this organization Notice of Privacy Practices
- Please sign *