

HIPAA CONSENT FORM

**TO THE USE AND /OR DISCLOSURE OF PROTECTED HEALTH INFORMATION
FOR THE TREATMENT, PAYMENT, HEALTH CARE OPERATIONS, AND AS
OTHERWISE ALLOWED BY LAW**

Columbus W. Floyd, M.D. will maintain a record of the care and services you receive at this practice. This consent only covers your protected health information created while you are a patient. Your protected health information pertains to your diagnosis and / or treatment at the practice, including but not limited to information concerning mental illness except for psychotherapy notes, use of alcohol or drugs or communicable diseases such as Human Immunodeficiency Virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS), laboratory test results, medical history, treatment progress or any other related information.

By signing this form, you consent to COLUMBUS FLOYD, M.D. use and / or disclosure of protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. Our Notice of Protected Health Information Practices provides information about how COLUMBUS FLOYD, M.D. and his staff may use and / or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. By signing this form, you also acknowledge that you have received a copy of COLUMBUS FLOYD, M.D. Notice of Protected Health Information Practices and have had an opportunity to review it before signing this consent.

Patient Name:

DOB:

Signature of Patient/Legal Representative

Witness

Date