

**Lakeside Primary Care**  
**Written Acknowledgement and HIPAA Consent Form**

I, \_\_\_\_\_, *(Please print patient name)* have been provided a copy of Lakeside Primary Care's Notice of Privacy Practices.

I have had an opportunity to read the Notice of Privacy Practices.

I understand that I may ask questions of the medical practice if I do not understand any information contained in the Notice of Privacy Practices.

HIPAA is the Health Insurance Portability and Accountability Act of 1996.

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our Notice of Privacy Practice before signing this consent. As provided in our notice, privacy practices may change in accordance with changes in Federal regulations. A current copy may be obtained by requesting one from a member of our staff.

You have the right to request that we restrict how protected health information is used or disclosed. Please list below all the people you give us permission to disclose your protected health information to:

\_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
\_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
\_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
\_\_\_\_\_ Relationship to patient: \_\_\_\_\_

By signing this form you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

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