OverSightMD Inc.
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HIPAA PATIENT CONSENT FORM
NOTICE OF PRIVACY PRACTICES

Our **Notice of Privacy Practices** ("Notice") provides information about how we may use and disclose protected health information about you. The Notice contains a Patients Rights section below describing your rights under the law. You have the right to review this Notice and our HIPAA Notice of Privacy Practices available at www.oversightmd.com/hipaanotice before signing this consent form. By signing this form, you consent to our use and disclosure of Protected Health Information about you. OverSightMD, Inc. provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands his/her Patient's Rights as follows:

- Protected Health Information may be disclosed or used for care communications, care coordination, including with third-party providers, payment, and care oversight and operations, or as described in our HIPAA Notice of Privacy Practices.
- You have the opportunity to review this Notice and our Notice of Privacy Practices.
- OverSightMD reserves the right to change the HIPAA Notice of Privacy Practices and you have the right to obtain a copy by requesting a copy from the above address.
- You have the right to restrict the use of your information but OverSightMD does not have to agree to those restrictions.
- You may revoke this consent in writing at any time and all future disclosures will cease.
- OverSightMD may condition receipt of services upon the execution of this consent form.

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent form.

______________________________ ______________________
Patient's Name Printed Date of Birth

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Signed (Patient or Legal Representative for Patient) Date

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Legal Representative's Relationship to Patient