



HIPAA PATIENT/CLIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for consultations, payment, or clinical operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for consultations, payment, and clinical operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. Dr Bramstedt/AskTheEthicist.com provides this form in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The client/patient understands that:

- Protected health information may be disclosed or used for consultations, payment, or clinical operations.
- Dr Bramstedt/AskTheEthicist.com has a Notice of Privacy Practices and that the client/patient has the opportunity to review this notice.
- Dr Bramstedt/AskTheEthicist.com reserves the right to change the Notice of Privacy Practices.
- The client/patient has the right to restrict the uses of their information but Dr Bramstedt/AskTheEthicist.com does not have to agree to those restrictions.
- The client/patient may revoke the Consent in writing at any time and all future disclosures will then cease.
- Dr Bramstedt/AskTheEthicist.com may condition receipt of consultation upon the execution of this Consent.

This Consent was signed by:

Printed Name – Client/Patient or Representative

_____/_____/_____

Signature Date

Relationship to Client/Patient

Witness:

Printed Name

_____/_____/_____

Signature Date

Katrina A. Bramstedt, PhD