FAIRBANKS PSYCHIATRIC & NEUROLOGICAL CLINIC, P.C.
1919 Lathrop Street, Suite 220, Fairbanks, AK, 99701 Phone: (907) 452-1739 Fax: (907) 452-2384

Consent Form

I, the undersigned, understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). I understand 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 my treatment, directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations, such as physician certifications and quality assessments.

This Clinic has informed me of its **Notice of Privacy Practices**, which contains a more complete description of the uses and disclosures of my protected health information. I have been given the right to review this **Notice** prior to signing this consent. I understand this Clinic has the right to update this policy as needed, and that I may contact this Clinic to obtain a current copy.

I understand that I may request in writing for this Clinic to restrict how my private information is used and disclosed, and that its relevant staff are not required to agree to my requested restrictions. However, if the relevant staff do agree, this Clinic is bound to abide by those restrictions, unless required by law.

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

Patient's Printed Name: ____

Patient's/Guardian's Signature: _______________________________________

If Guardian, Relationship to Patient: ______________________

Date: _____________________________