

**Jeff M. Bauman, Psy.D., P.A. and Associates**

**HIPAA CONSENT**

**This form is an agreement between you and this practice. When we use the word “you” below, it can mean you, your, child, a relative, or other person if you have written his/her name here Patient Name)\_\_\_\_\_.**

**Your signature here certifies your consent that we may use/share your Protected Health Information as described in the HIPAA PRIVACY NOTICE you have received. Please make sure to read that document and ask us any questions.**

**After you have signed this consent, you have the right to revoke it (by writing a letter to Dr. Bauman). We will then comply with your wishes from that time forward. Of course we cannot do anything about information shared previous to your revocation.**

\_\_\_\_\_  
**Signature of patient or his/her personal representative    Date**

\_\_\_\_\_  
**Printed name of patient or personal representative    Date**

\_\_\_\_\_  
**Relationship to patient**