HIPAA Acknowledgment and Consent Form

Patient Name:_____ Date of Birth_____

Disclosure of personal health information: I give my permission for Kevin B Horton, MD to discuss my protected health information with the following person(s):

	Name	Relationship	Contact phone number
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Consent for photographing or other recording:

_____(pt/representative initials) I consent to the usage of photography, digital or audio recording or images of me for my care or security purposes. I understand that the medical practice retains ownership rights to the images or recordings and that I may request access to or copies of the images or recordings when technologically feasible unless prohibited by law and that these will be maintained as part of the medical record.

-OR-

_____(pt/representative initials) I do not consent to the usage of photography, digital or audio recording or images of me for my care or security purposes.

I understand that the above authorization(s) my be revoked at any time by designating in writing.

Patient signature: _____ Date_____

Patient's legal representative, if applicable (*documentation of authorization, such as medical power or attorney or guardianship, required to be provided*) to sign below:

Name of legal representative_____

Signature_____Date_____

Witness name_____

Witness Signature_____ Date_____