Alancia C. Wynn, MD
WYNN FAMILY MEDICINE, PLLC
8316 Arlington Blvd #234
Fairfax, VA 22031
703-560-0300(ph) 703-560-8679(fax)

Consent for the use and disclosure of Protected Health Information (HIPAA)

Patient Name:_____ **Date:**_____

Mailing Address: _____

Phone: _____

Parent/Guardian(if under 18):_____

Relationship to Patient: ☐**Self** ☐**Parent** ☐**Legal guardian** ☐**Other(explain)**

Purpose of consent- I am giving consent to Alancia C. Wynn, MD & WYNN FAMILY MEDICINE, PLLC to use and disclose protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices~ I have the right to read the Notice of Privacy Practices before I decide whether to sign this consent. The notice provides a description of the manner in which we may use and disclose your protected health information.

I reserve the right to revoke this consent at any time by giving a written notification, and the practice may decline to treat or continue to treat me as a result of the revocation of this consent.

Protected health information may be released to the following: (spouse, children, etc)

1. _____(name/relationship)

2. _____(name/relationship)

Protected health information may be released to other covered entities for use in treatment, payment activities, and healthcare operations. I understand that I have a right to inspect and obtain copies of PHI. (In accordance with federal privacy regulations 45CFI 164.524). I understand that I do not have to sign this consent, and that my refusal to sign will not affect my eligibility for benefits. I also have a right to obtain a copy of this consent form.

X_____ X_____

Signature (parent/legal guardian if under 18) **Date**