Siyan Clinical Corporation

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Acknowledgement of HIPAA Notice of Privacy Practices

By signing this form, I_____ consent to Siyan Clinical Corporation's to use and disclosure of my protected health information (PHI) for the following purposes:

- To provide treatment, including communication with multiple healthcare providers who may be involved in treatment directly or indirectly
- To obtain payment for services provided to you through third-party payers
- To conduct normal healthcare operations such as quality assessments, etc.

_____I have been informed I can access a copy of the HIPAA Notice of Privacy Practices on Siyan Clinical Corporation's website Siyanclinical.com or posted in the waiting room. At any time, I can ask for a copy of the HIPAA Notice of Privacy Practices (HNOPP).

_____Siyan Clinical Corporation reserves the right to change our privacy practices as described in our HNOPP. If we change our privacy practices, we will issue a revised HNOPP, which will contain the changes. Those changes may apply to any of your PHI that we maintain.

_____I understand that I have the right to revoke this consent at any provided in writing. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

_____I have had a full opportunity to read and consider the contents of this consent form and this office's NOPP. I understand that, by signing this consent, I am allowing Siyan Clinical Corporation's use and disclosure of my PHI to carry out treatment, payment activities, and healthcare operations.

_____ _____
Print Patient Name Print Guardian Name

_____ _____
Patient/ Guardian Signature Date

OFFICE USE ONLY

_____ Individual Refused to Sign

_____ _____
Signature of Office Supervisor Date

Last Revised: 5/1/2018