HIPAA Privacy Rule Patient Consent and Acknowledgment

I consent to the use of disclosure of my protected health information by the facility, for the purpose of providing me with health care treatment, getting paid for those services, and conducting the health care operation portion of its business. I also acknowledge that I received and read the facility's Notice of Privacy Practices.

I understand the following:

- "My protected health information" ("PHI") means my health related information either collected from me or received by the facility from any other source, and it includes information about my past, present and future physical or mental health.
- If I refuse to sign this Consent and Acknowledgment, the facility has the right to refuse me as a patient.
- I have the right to ask the facility, in writing, to limit the way in which it uses or discloses my protected health information but the facility does not have to agree to my request. However, if the facility does agree, thin it is bound by that agreement.
- I have the right to revoke the Consent portion of this document at any time by providing the facility with a written request specifically stating my desire to revoke my consent to the facility use of my PHI. The facility must accept this revocation but may then refuse to provide me with further health care treatment.
- If I revoke the consent portion of this document, it is effective except to the extent that the facility has already used or disclosed my protected health information in reliance on this Consent and Acknowledgment.

Before I signed this Consent and Acknowledgment, I reviewed the facilities Notice of Privacy Practices and understand the following with respect to the Notice:

- The facility has the right to change the terms of the Notice at any time but if it does, it must post the new Notice in the waiting room and give me a copy if I request one.
- The Notice describes in detail, the types of uses and disclosures of my protected health information that the facility may make in treating me, getting paid for that treatment of in carrying out its health care operations.
- The Notice also describes my rights with respect to my protected health information and the facility's obligations to protect the confidentiality of that information.

I have read and understand this information and have received a copy of this Consent and Acknowledgment. I am the patient or I am authorized to act on behalf of the patient for the reason described below.

_____ _____

Patient or Personal Representative Signature Date

_____

Printed name of signatory

_____

Description of Personal Representative's Authority