Consent to Treat/Disclosure of Health Information

Name:_____

Birthdate:_____ **Social Security #**_____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms examination and test results, diagnoses, treatment and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.

I understand that I have the right:

- To object to the use of my health information for directory purpose.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations - and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

X_____

Signature of Patient or Legal Representative Date Witness Signature

Notice Of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions

I give consent to Minden Family Care Center, its healthcare providers and all of its employees to contact me by any means available including e-mail, fax, phone or any other medium appropriate in order to contact me for business or healthcare reasons including appointment reminders unless I indicate otherwise in writing.

Patient:

X_____

Signature of Patient or Legal Representative Date Witness Signature

Office use only:

- ☐ **Accepted**
- ☐ **Denied**

X_____

Signature Title Date