I consent to the use or disclosure of my protected health information by this facility, including its employees, physicians and agents for the purposes of diagnosing or providing treatment, obtaining payment for my health care bills or to conduct health care operations of this facility. I understand that diagnosis or treatment of me by this facility may be conditioned upon my consent as evidenced by my signature of this document.

I understand that I have the right to request restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of this facility, its employees, physicians, or agents. However, I understand that this facility is not required to agree to the restrictions that I may request. If the facility agrees to the restriction that I request, the restriction is binding on the facility.

I have the right to revoke this consent, in writing, at any time, except to the extent that the facility has taken action on this consent.

My protected health information means health information, including my demographic information collected from me and created or received by this facility, my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information may relate to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe that the information may identify me. It may also refer to alcohol, drug abuse, communicable disease including HIV status, and/or psychiatric diagnosis complied during my visit, encounter or hospitalization.

I understand that state law requires the Facility to report certain positive test results, such as hepatitis and the antibody for HIV/AIDS virus to the Health Department. My medical information described above and appropriate records as permitted by law may be disclosed and released to any such persons or organizations upon their request both during and after my facility stay. I understand and agree that federal and state entities, including but not limited to, the Centers for Medicare and Medicaid Services, the state Department of Health and Joint Commission on the Accreditation of Healthcare Organizations, may have access to my medical records.

I discharge and release the Facility and its employees from any responsibility and liability arising out of the disclosure or use of such information by such persons and organizations. I also authorize the release of my medical information to the physician (s) listed as my personal or family physician (s) upon registration and to any referral physicians.

NOTICE OF PRIVACY PRACTICES:

Required pursuant to Health Insurance Portability and Accountability Act of 1996 (H.I.P.P.A.).

I acknowledge that I have received a copy of the Facility's Notice of Privacy Practices that provides information about how the facility may use and disclose my protected health information.

_____

The undersigned certifies that he/she has read the foregoing, understands it, accepts its terms, has received a copy of it (if requested) and is the patient or is duly authorized by the patient as their agent to execute the above.

_____

Patient's Signature or Authorized Party: Date: Time: AM/PM

Relationship to Patient: Interpreter, if utilized:

_____

Witness Signature: If Telephone Consent, Second Signature Witness

_____

I acknowledge that I have read a copy of the facilities notice of privacy practices that provides information about how the facility may use and disclose my protected health information.

Sign/Date: _____