West Salem Family Practice Associates, LLC

ACKNOWLEDGMENT AND CONSENT TO USE/DISCLOSE PROTECTED HEALTH INFORMATION (HIPAA)

PATIENT NAME (PLEASE PRINT) _____ DATE OF BIRTH _____

I understand that West Salem Family Practice Associates, LLC (WSFPA) will use and disclose health information about me. I understand that this may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health, history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions and similar types of health related information.

I understand and agree that WSFPA may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment;
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care;
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how WSFPA will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, physicians and other personnel of WSFPA, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of the Notice of Privacy Practices upon my request.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that WSFPA is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and, if I requested, that I have received a copy of the Notice of Privacy Practices.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE _____ **TODAY'S DATE** _____

I would also like to give permission for _____ to:
PLEASE PRINT NAME OF FAMILY MEMBER OR REPRESENTATIVE

Discuss information regarding my appointments, my account balances, my medical conditions, including results, printing and release of medication lists, and to leave phone messages on my listed phone number with this person or on voicemail of which they may have access.