WEST VILLAGE REHABILITATION AND NURSING CENTER
HIPAA Authorization Form

Consent for the Use or Disclosure of Health Information For Treatment, Payment or Health Care Operations

I understand that as part of my health care, the Facility and the physician(s) who care for me originate and maintain 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, to arrange for the billing and payment of my care and to carry out routine health care operations, such as assessing quality.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the Facility reserves the right to change its notice and practices, and that prior to implementation of those changes will mail a copy of the revised notice to me. I have been informed that if I refuse to sign this consent for the use and disclosure of my health information, then the Facility may refuse to admit me or treat me in any manner.

I understand that I have the right to:

- Object to the use of my health information for directory purposes.
- Request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations, and that the Facility is not required to agree to the restrictions requested. If the Facility agrees to any restrictions, then it is bound by those restrictions.
- Revoke this consent in writing, except to the extent that the Facility has already taken action in reliance thereon. I understand that if I revoke my consent, then the Facility will no longer be able to treat me, and that I will need to be discharged from the Facility.

I consent to the use and disclosure by the Facility and its agents or representatives, and the physicians who care for me, of all my health information for treatment, payment and health care operations (as more fully articulated in the Notice of Privacy Practices).

I have read and understood this consent form. I have had the opportunity to ask questions, and have had all of my questions answered to my full satisfaction.

Signature

Date

_____

Print Name

_____

Resident's Name

Room #

File #