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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose: This form is to obtain an individual's written permission under federal and state laws for (a) our use of the individual's patient health care records, HIV test results, and mental health treatment records to carry out treatment, payment activities and health care operations, and (b) our disclosure of the individual's patient health care records to carry out treatment, payment activities, and health care operations. This form should not be used to obtain written permission for the disclosure of mental health treatment records or HIV test results unless the name of the recipient is listed on this form.

SECTION A: Individual Giving Consent

Name:_____ (PRINT NAME HERE, READ, THEN SIGN AT THE BOTTOM)

TO THE INDIVIDUAL: Please read the following and complete the information requested.

Effect of Declining Consent: This consent is a condition of treatment by us and if you decide not to sign it, we may decline to treat you.

Privacy Practices Notice: You have the right to read our Privacy Practices Notice before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and health care operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

SECTION B: The uses and disclosures being authorized.

Our Use of Medical Information: By signing this form, you consent to our use of your patient health care records, mental health treatment records, and HIV test results to carry out treatment, payment activities, and health care operations as set forth in our Privacy Notice.

Facility Directory and Persons Involved in Care: By signing below, you indicate your consent to:

- Our listing of my general condition in our facility directories.
- Our disclosure of your patient health care records, mental health treatment records, and HIV test results for disaster relief purposes as permitted by law, and to the following persons, including those involved in your care or payment for that care.
- We may use professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person acting on your behalf to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of protected health information.

Our Disclosure of Medical Information: By signing this form you will consent to our disclosure of your patient health care records to carry out treatment, payment activities, and health care operations as set forth in our Privacy Practices Notice.

SECTION C: Revocation.

Right to Revoke: This consent is effective until revoked by you. You may revoke this consent at any time by giving written notice of revocation to the Contact Person on our Privacy Notice. Revocation of this consent will *not* affect any action we took in reliance on this authorization before we received your written notice of revocation. We may decline to treat you or to continue treating you if you revoke this consent.

INDIVIDUAL'S SIGNATURE.

I have had full opportunity to read and consider the contents of this consent. I understand that, by signing this form, I am confirming my written permission for the use and disclosure of my health information, as described in this form.

Signature: _____ Date: _____

If this consent is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____ Relationship to Individual: _____