HIPAA NOTICE OF PRIVACY RIGHTS

I understand that I have certain rights to privacy regarding my protected health information (PHI). These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information (PHI) to carry out:

Treatment: We will use and disclose your protected health information (PHI) to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to treat you.

Advance Directive/Living Will: I understand that if an emergency medical condition should occur I will be transferred to the closest hospital for further evaluation and treatment. I understand that if I have an Advance Directive or Living Will, the center will still transfer me to a hospital which will make decisions about following any advance directives or living will. I also consent to the hospital to release copies of my medical records to the center to review the episode of care. I understand that I will give a copy of my Advance Directive/Living Will to Coastal Mental Health Center to be placed in my Medical Record in the case of future need.

I have a Psychiatric Advance Directive or Living Will: ☐ Yes ☐ No

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining eligibility or benefits may require that your relevant PHI be disclosed to the health plan to obtain the information.

Operations: We will use and disclose your PHI in order to support the business activities, licensing and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk: we may also call your name in the waiting room when your clinician is ready to see you.

Appointment Reminders: We may use or disclose your PHI to provide you with appointment reminders, including but not limited to voicemail.

Restrictions: I understand that I have the right to request restrictions on how my PHI is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

Revocation of Authorization: I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

_____ _____

Signed this on Date Print Patient Name

_____ _____

Signature Relationship to Patient