Patient ID# P _____ ☐ SCAN ID

ASSURED HEALTH CLINIC

8421 W Broadway Ave, Brooklyn Park, MN, 55445

Patient Name (LAST, FIRST, MIDDLE): _____
Last First MI

Date of Birth: _____ **Race/Ethnicity:** _____

Address: _____ **City:** _____ **Zip:** _____

Phone: _____ **Email:** _____

I the undersigned,

- Acknowledge that it is my responsibility to pay for all charges
- Acknowledge the receipt of the Notice of Privacy Practices. If you have any questions concerning your rights and/or our privacy practices, please contact Assured Health.
- Authorize Assured Health to release information from the patient's health records for purposes of processing and paying claims, coordinating benefits, coordinating care, quality care review studies, and other functions that support treatment, payment and healthcare operations, including those functions that my caregiver is required by my health plan or other third-party payers to perform.
- Authorize the patient's health plan to release health information to appropriate accreditation and quality review/measurement personnel, to disease, pharmacy, or case management providers and to other third parties for purposes related to treatment, payment, or healthcare operations.
- Acknowledge that I have the rights with respect to my protected health information (PHI):
  *The right to reasonable requests to receive confidential communication of my PHI
  * The right to inspect and copy my PHI
  * The right to receive an accounting of disclosures of my PHI
  * The right to request an amendment of my PHI
- Acknowledge that I understand that I may revoke (cancel) this consent, in writing anytime. Revoking consent does not apply information that has already been disclosed.

_____ _____
PRINT Name of Guardian/Legal Representative Relationship to Patient

_____ _____
SIGNATURE of Patient or Legal Representative Date