HIPAA COMPLIANCE

Patient Name:	ID#:

I have received the Organized Health Care Arrangement (OHCA) Joint Notice of Privacy Practices and consent to the OHCAs use and disclosure of protected health information for the purposes as stated in the HIPAA JOINT NOTIFICATION OF PRIVACY PRACTICES. I understand the company members of the OHCA create and maintain health records and other information describing among other things, my health history, symptoms, examination, test results, diagnosis, treatment, and any plans for future care or treatment.

I have been provided with a Joint Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior so signing the consent. I understand that the OHCA reserves the right to change their Notice and practices prior to implementation and will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my protected health information for directory purposes. I understand that I have the right to request restriction as to how my health information may be used or disclosed to carryout treatment, payment, or healthcare operations. The organization is not required to agree to the restrictions requested. By signing this form, I consent and authorize the OHCA to disclose treatment records, assessment reports, progress notes and any other information necessary to the patient's school, physician, and/or any other person or entity that would assist in patient's speech, occupational and/or physical therapy program, payment and health care operation. I have the right to revoke this consent, in writing, except where disclosures have already been made on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I have had the right to request that the use of my Protected Health Information, which is used or disclosed for purposes of treatment, payment, or health care operations, be restricted. I also understand that the Practice and I must agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information, which have been previously agreed upon.

Can we contact other family members or other individuals about the patient's general information & diagnosis?	Yes	No

If yes, please list whom we may inform about the patient's general information and diagnosis (including treatment, payment and health care operations):

Name:	Phone:	Name:	Phone:

Can we contact family members or other individuals, about the patient's medical condition only in an emergency?	Yes	No

If yes, please list name & phone:

Name:	Phone:	Name:	Phone:

Can we contact you via telephone number?	Yes	No

If yes, please provide number where we can call about the patient's appointments, test results or additional health information

Home:	Alternate Phone:

The undersigned certifies that they have read the foregoing, received a copy thereof, and is the patient or patient's legal representative to execute the above and accept its terms.

Signature of Patient, Parent or Legal Guardian	Date