

HARRISON HEALTH PARTNERS

Acknowledgement of Receipt of the Notice of Privacy Practices:

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may ask the provider to amend the record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may ask to review your record and obtain a copy of your record. Requests must be made in writing and will be processed within 14 days.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

Signature of patient or legally authorized individual

Date

Privacy Consents:

I agree to permit the practice to request and obtain previous medical records from or forward records to other providers if deemed necessary to provide me with proper care and treatments.

I agree to the release of all my insurance and medical information to other health care providers, my insurance company, Medicare or any third party payer to facilitate health care, processing of claims and audit of payments. I understand that the information released may need to include records regarding HIV/AIDS, sexually transmitted diseases, mental health and drug and alcohol abuse treatment health information.

***I agree** to be contacted for routine appointments or follow-up information regarding my care by phone, by answering machine, by mailed appointment card reminders.

***I agree** to allow the practice to use and disclose information regarding my care without restrictions or limits to **family members** and _____.

***I agree** to be contacted regarding treatment options and health-related benefits regarding medical options that may improve my quality of life.

I understand that I am financially responsible for any and all charges my insurance does not pay. I also agree to pay any finance charges or collection fees that should arise from nonpayment.

These consents will remain in effect until revoked by me in writing.

Signature of patient or legally authorized individual

Date

Print name if signed on behalf of the patient

Relationship – parent, legal guardian, personal representative

***If you disagree with or wish to qualify this item, please ask for a “Patient Opt-Out Consent Form.”**

Do you have a Living Will?YES / NO

Do you have a Durable Power of Attorney for health care? YES / NO

If not, do you wish to have additional information? YES / NO

The existence or execution of a living will, durable power of attorney for health care, or other written advance directive is not a condition of receiving health care services and may not otherwise be used to discriminate against an individual.