Parkview Health Services- Protected Health Information Consent & Acknowledgement of Receipt of Notice of Privacy Practices

Print Individual's Name: _____

Print Agency/ Home/Location: _____

Please complete BOTH signature boxes (Part I and Part II)

Part I. Consent to disclose Protected Health Information

SIGNATURE

I have read and understand the terms of this consent. I have had an opportunity to ask questions about the use or disclosure of my Protected Health Information.

Signature of Individual or Personal Representative:_____

Date: _____

If Signed by a Personal Representative, Complete the Following:

Print Name of Personal Representative:_____

Description of Personal Representative's Authority:_____

CONTACT INFORMATION

Contact information of the personal representative who signed this form:

Address:_____

_____

Telephone: _____(Daytime) _____(Evening)

Part II. Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of Parkview's Notice of Privacy Practices and have been advised of how Parkview will handle my Protected Health Information. I have also been advised of my rights to obtain access to and control my Protected Health Information. I understand that I may receive other notices which describe how Parkview will handle specialized forms of Protected Health Information such as HIV/AIDS-related, alcohol and drug abuse information.

SIGNATURE

Print Name of Patient or Personal Representative:_____

Signature of Patient or Personal Representative:_____

Date: _____

Please complete and fax to: 716-876-1349

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