Acknowledgement of Receipt of Notice of Privacy Practices
and
Consent to Use and Disclose Protected Health Information for Treatment, Payment and Health Care Operations

EXAMPLE

I Acknowledge That:

- I have received a copy of Person Centered Services' HIPAA Notice of Privacy Practices.
- I have been advised of my rights to obtain access to and control my Protected Health Information (PHI) and I understand that I may contact Person Centered Services to obtain more information about those rights and the uses and disclosures of my PHI.
- I authorize the use and disclosure of my PHI by Person Centered Services and its workforce members, health care professionals and vendors providing services or supplies to me for the purposes of treatment, payment and health care operations.
- I understand New York laws require my consent before Person Centered Services may use or disclose my PHI for its treatment, payment or health care operations.
- I understand that this information may be used or disclosed by Person Centered Services to:
    - coordinate or provide for my care, treatment and services;
    - communicate among various health care and other professionals who are involved in my care, treatment and services;
    - obtain payment for services provided by Person Centered Services;
    - provide information to and obtain payment from Medicaid or other health insurer;
    - assess and review the quality of my care, treatment and services; and
    - conduct its business and health care operations.
- I understand that my signature on this consent is required in order for me to receive care, treatment and services from Person Centered Services and that Person Centered Services may condition my care, treatment and services on obtaining my consent for use and disclosure of my PHI for treatment, payment and health care operations.

By signing below, I also acknowledge that:

- I have read and understand the terms of this consent.
- I have had an opportunity to ask questions about the use and disclosure of my PHI.

Name of Individual Seeking Services

(If the Individual is under the age of 18, please write Minor Child) or
Individual's signature **(if age 18 or older)**

____
Print Name of Individual

____
Signature of Individual

<u>Complete the following if the individual receiving services is a minor or has a guardian or representative:</u>

____
Name of Individual's Representative

____
Description of Relationship to Individual/Authority

____
Signature of Individual's Representative

____
Phone Number of Representative

Date: ________________________

Acknowledgement of Receipt of Notice of Privacy Practices and Consent to Use and Disclose Protected Health Information for Treatment, Payment and Health Care Operations

I Acknowledge That:

- I have received a copy of Person Centered Services' HIPAA Notice of Privacy Practices.
- I have been advised of my rights to obtain access to and control my Protected Health Information (PHI) and I understand that I may contact Person Centered Services to obtain more information about those rights and the uses and disclosures of my PHI.
- I authorize the use and disclosure of my PHI by Person Centered Services and its workforce members, health care professionals and vendors providing services or supplies to me for the purposes of treatment, payment and health care operations.
- I understand New York laws require my consent before Person Centered Services may use or disclose my PHI for its treatment, payment or health care operations.
- I understand that this information may be used or disclosed by Person Centered Services to:
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    - communicate among various health care and other professionals who are involved in my care, treatment and services;
    - obtain payment for services provided by Person Centered Services;
    - provide information to and obtain payment from Medicaid or other health insurer;
    - assess and review the quality of my care, treatment and services; and
    - conduct its business and health care operations.
- I understand that my signature on this consent is required in order for me to receive care, treatment and services from Person Centered Services and that Person Centered Services may condition my care, treatment and services on obtaining my consent for use and disclosure of my PHI for treatment, payment and health care operations.

By signing below, I also acknowledge that:

- I have read and understand the terms of this consent.
- I have had an opportunity to ask questions about the use and disclosure of my PHI.

______________________________	______________________________
Print Name of Individual	Signature of Individual

Complete the following if the individual receiving services is a minor or has a guardian or representative:

______________________________	______________________________
Name of Individual's Representative	Description of Relationship to Individual/Authority
______________________________	______________________________
Signature of Individual's Representative	Phone Number of Representative

Date: ____________________