Eastside Family Health Center: Consent Form

I, _____, consent to the use or disclosure of my protected health information by Eastside Family Health Center for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct healthcare operations of Eastside Family Health Center. I understand that diagnosis or treatment of me by Frank Marinkovich M.D. or Rita Marinkovich, A.R.N.P. (who are hereafter referred to as PROVIDER) may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The PROVIDER is not required to agree to the restrictions that I may request. However, if the PROVIDER agrees to a restriction that I request, the restriction is binding on Eastside Family Health Center and the PROVIDER

I have the right to revoke this consent, in writing, at any time, except to the extent that the PROVIDER or Eastside Family Health Center has taken action in reliance on this consent.

"Protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review Eastside Family Health Center's Notice of Privacy Practices prior to signing this document. Eastside Family Health Center's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of use and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Eastside Family Health Center. The Notice of Private Practices also describes my rights and Eastside Family Health Center's duties with respect to my protected health information.

Eastside Family Health Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by contacting the Privacy Officer at the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information. The individual is also provided the right to request confidential communications or that a communication of public health information be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

- ☐ Home Telephone _____
  - ☐ O.K. to leave message with detailed information
  - ☐ Leave message with call-back number
  - ☐ O.K. to leave message with spouse
- ☐ Work Telephone _____
  - ☐ O.K. to leave message with detailed information
  - ☐ Leave message with call-back number
- ☐ Cell Telephone _____
  - ☐ O.K. to leave message with detailed information
  - ☐ Leave message with call-back number
- ☐ Written Communication
  - ☐ OK to mail to home address
  - ☐ OK to fax to this number _____

_____ _____

Signature of Patient or Personal Representative Date

_____

Description of Personal Representative's Authority