4424 S. Eastern Ave., Las Vegas NV 89119
Tel: 702-732-7440

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES & PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS IN ACCORDANCE TO HIPAA

In signing this form, I understand that as a part of my health care, **CARING HEALTH CENTER** originates, collects, and maintains paper and/or electronic records describing my health history, symptoms, examinations, test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer (s) can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent/disclosure and the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations.

I understand that **CARING HEALTH CENTER** is not required to agree with the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.520 of the Code of Federal Regulations.

I understand that as part of this organization's treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity (Insurance company, referring physician, consulting physician, hospital, etc.), and I consent to such disclosure for these permitted uses, including disclosures via fax or email. I further grant **CARING HEALTH CENTER** permission to access my medication history for purposes of my treatment. In addition, I also give consent to **CARING HEALTH CENTER** to disclose my protected healthcare information to the following person and/or people, including but not limited to mental health, HIV related information, alcohol and drug abuse information:

Name Phone Number	Relationship:
Name Phone Number	Relationship:
Name Phone Number	Relationship

I fully understand and accept the terms of this consent.

X_____ _____

Patient/Legal Guardian Signature Date

Revised 5/1/2016