

POSEY COUNTY HEALTH DEPARTMENT

CONSENT FOR USE AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

The Posey County Health Department may use and disclose my protected health information to carry out treatment, payment, and health care operations.

I have been offered a copy of the Notice of Privacy Practices, which details the use and disclosure of protected health information before signing this consent.

I have the right to ask for restrictions on the use and disclosure of my protected health information to carry out treatment, payment, or health care operations. I understand that the Posey County Health Department is not required to agree with these restrictions.

I have the right to revoke this consent in writing, except to the extent that actions have been taken based on prior consent.

By signing this form, I consent to the use and disclosure of protected health information for treatment, payment, and health care operations.

Printed Client Name

Employee Signature

Street Address of Client (*IC 16-39-1-4*)

Date

City, State, Zip code

Signature of Client/Personal Representative

Relationship of Personal Representative

___ Client declines to acknowledge Privacy Notice for the following reason(s):

This consent was revoked on _____
Date