

# *North Coast Family Foundation*

## **Privacy Consent – For the Use and Disclosure of Protected Health Information**

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.

**I hereby give my consent to NORTH COAST FAMILY FOUNDATION to use and disclose my protected health information for the purposes of treatment, payment and operations of my health care and this practice.**

**Consent for treatment:** I, with my signature, authorize NORTH COAST FAMILY FOUNDATION, and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but limited to) preventive, diagnostic therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professional for care and treatment.

**Consent for release of information for payment and operations:** I also authorize NORTH COAST FAMILY FOUNDATION to furnish information to the identified insurance carrier(s) for any and all payment activities. I further consent to the use for any practice operational needs as identified in the practice privacy notice.

**Consent related to the Privacy Statement:** I have had a chance to review The Practice Privacy Statement as part of this registration process. I understand that the terms of the Privacy Statement may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

**Consent for assignment of benefits:** I consent to assign all payments for these services to NORTH COAST FAMILY FOUNDATION. I understand that I am responsible for all co-payments, amounts applied to deductibles and other amounts that may be deemed my responsibility by the payment sources, as required by my contract with my insurance plan and state regulation. I further understand that my contract with my insurance entity may or may not cover some services. It is my responsibility to obtain information from my health plan about service coverage. If I seek care outside of the contract, I am aware that I may be responsible for all charges that are incurred.

I understand that NORTH COAST FAMILY FOUNDATION may refuse me services if I refuse to sign this consent. I may revoke this consent at any time, but NCFE may refuse further services at that time. If I revoke this consent, the revocation does not take affect until NCFE receives it.

Patient/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Name printed: \_\_\_\_\_

If not patient, relationship: \_\_\_\_\_

### **Revocation:**

**I hereby revoke the consent given above:**

Patient/Guardian \_\_\_\_\_

Date: \_\_\_\_\_

Name printed: \_\_\_\_\_

If not patient, relationship: \_\_\_\_\_