OAK GROVE FAMILY MEDICAL CLINIC

2250 Southeast Oak Grove Blvd., Suite B
Oak Grove, Oregon 97267
Phone: (503) 654-6567
FAX: (503) 653-2582

HIPAA ACKNOWLEDGEMENT AND CONSENT

I (***print patient name)***_____**, understand that Oak Grove Family Medical Clinic** (referred to below as "This Practice") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by This Practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnosis, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may use and disclose my **health information** in order to:

- make decisions about and plan for my care and treatment;
- remind me of appointments;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my healthcare; and
- perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy of This Practice's Notice of Privacy Practices that is in effect will be posted in the waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I undestand that The Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above. A copy of the Notice of Privacy Practices is available upon request.

Sign: _____ Date: _____
Patient

- OR -

Sign: _____ Date: _____
Patient Representative (if minor is under 18)

Description of Prepresentative's Authority:_____