

Consent to Use Protected Health Information

To provide for your healthcare, **Clinica Salud & Familia** collects information about your medical history. Physical examination and test results, diagnoses, and treatments. Use and disclosure of protected health information is regulated by a federal law known as the Health Insurance Portability and Accountability Act of 1996. (HIPAA) Under HIPAA, providers of healthcare may decide to obtain your consent to use personal health information for treatment, payment, or healthcare operations, but are not required to do so.

Therefore, I, _____ (printed name of patient or personal representative) consent that **Clinica Salud & Familia** may use the health information of (check one) () myself or () (specify) _____ For the following purposes:
(If signing as personal representative, documentation of your legal right to do so must be provided)

1. Treatment (to perform actions required to help diagnose, maintain, or improve health)
2. Payment (To obtain reimbursement from thirds party payers)
3. Healthcare operations (to carry out, analyze, or improve business processes related to healthcare)

Clinica Salud & Familia has privacy practices that are summarized in our Notice of Privacy Practices for Protected health Information (Notice). This notice describes the use and disclosure of protected health information, patients' right relevant to examining medical records, requesting corrections and additions to these records, requesting restrictions to the use of health information, finding out to whom their protected health information has been disclosed, and registering any complaints relevant to privacy issues. The Notice also describes how to receive these rights. I have been provided with or have previously received a copy of this notice and given the opportunity to review it prior to signing this consent. I understand that if I decide not to sign this consent, **Clinica Salud & Familia** may decline to provide healthcare to me.

The consent I am signing today covers this and all future healthcare activities performed for me by **Clinica Salud & Familia** with respect to treatment, payment and operations. This consent replaces and supersedes any previous consent I may have signed with **Clinica Salud & Familia** for such use of my healthcare information. If I wish to revoke this consent, such a request must be in writing. However, a revocation does not cover actions that have already been taken in reliance upon the consent previously in force. In addition, I understand that if I revoke this consent, then **Clinica Salud & Familia** may discontinue taking care of me.

Unless I object, my name location and general condition may be listed in a patient directory. Unless I object, my name and location may be disclosed to anyone asking for me by name. Unless I request otherwise, information about my health maybe disclosed to other people involved in my healthcare (e.g. family members, personal representative, those accompanying you for care). Unless I object, my religious affiliation maybe disclosed to members of the clergy.

I have the right to request restrictions or limitations as to how my protected health information will be used to carry out treatment, payment or healthcare operations. I understand That HIPAA does not require such requests to be accepted, but if restrictions are accepted, then they must be honored. I request the following restrictions to the use and/or disclosure of my health information: () **NONE** or **List below**:

Acknowledgment of Receipt of Notice of Privacy Practices

Use and disclosure of protected health information is regulated by a federal law known as The Health Insurance Portability and Accountability Act of 1996 (HIPAA). Under HIPAA, providers of healthcare are required to give patient their notice of privacy practices for Protected health Information and make a good faith effort to obtain a written acknowledgment that this notice was received.

Therefore, I, _____ (printed name of patient or personal representative), acknowledge that Clinica Salud & Familia has provided a written copy of its Notice of Privacy Practices for Protected Health Information to (check one) () Myself or () Specify, I can obtain a copy of this notice by request. _____
(If signing as a personal representative, documentation of your legal right to do must be provided.)

X _____
Signature of Patient Or Personal Representative Date Printed Name (Relationship to Patient if not self)

To be completed by Clinica Salud & Familia

We made a good faith attempt to provide the above name patient with a copy of our Notice of Privacy Practices for Protected Health Information, but we were not successful for the following reasons:

Printed Name Title X _____
Signature Date