CJ Medical Center
KEEPING YOU WELL

**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES AND 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, CJ MEDICAL 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 could be used to:

1. To get means of communication among health professionals who collaborate with my care.
2. To get as an information source for applying to my bill, when applicable.
3. To get the best way by which a third-party payer (s) can verify that services billed were actually provided.
4. To get as a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have received a ***Notice of Privacy Practices*** providing the complete description of information and disclosure uses. I understand that I have the right to review the notice before 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 ***CJ MEDICAL 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 or revoke this consent, this organization may refuse to treat me as permitted by *Section 164.520 of the Code of Federal Regulations.*

***eCFR:: 45 CFR 164.520 -- Notice of privacy practices for protected health information.***

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 ***CJ MEDICAL CENTER*** permission to access my medication history for purposes of my treatment. In addition, I also give consent to ***CJ MEDICAL CENTER*** to disclose my protected healthcare information to the following person, including but not limited to mental health, HIV-related information, alcohol, and drug abuse information:

| | |
|---|---|
| Name<br>Phone Number | Relationship |

I fully understand and accept the terms of this consent.

Date _____ Signature _____