Acknowledgment of Receipt of
Notice of Privacy Practices
And Consent to Use and Disclosure of
Protected Health Information

I am requesting services from (name the Linn County department):

____.

I acknowledge receipt of the Linn County Notice of Privacy Practices.

I consent to the use and disclosure of protected health information about me as described in the Notice of Privacy Practices and understand that no further consent is required by this organization to:

- *Provide treatment to me or arrange for treatment by another health care provider.*
- *Arrange for payment for services to me.*
- *Operate the business of this organization.*
- *Enable other health care organizations that provide treatment to me or pay for services to me to review the quality and appropriateness of care I receive and conduct other health care operations.*

I understand that information disclosed pursuant to this consent may be re-disclosed by the recipient of the information.

(*Most health care providers and all health benefit plans are obligated to follow federal rules and state laws for protection of the privacy of your health information. But those rules and laws do not apply to all organizations.*)

I understand that there is no time limit on this consent.

I also understand that I may revoke this consent at any time and that if I revoke this consent it will affect receipt of future services from this organization.

I am the person who is the subject of the health records that will be used or disclosed. I agree to use and disclosure of my health information as described in this consent.

______________________________ ______________
Signature Date

____
Printed Name

IF THIS CONSENT IS BEING GIVEN BY A PERSONAL REPRESENTATIVE COMPLETE AND ATTACH FORM "A" TO THIS DOCUMENT.

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Version 03.1

FORM A
CONSENT OF PERSONAL REPRESENTATIVE

I am the personal representative of ______________________________
Printed Name

whose records will be used or disclosed.

My relationship to them is :

____

(eg. Mother, legal guardian, Attorney in Fact)

I acknowledge receipt of the Linn County Notice of Privacy Practices and consent to the use and disclosure of their protected health information as described in the Notice on their behalf.

______________________________ ______________
Signature Date

____
Print Name

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