

## SALEM WOMEN'S CLINIC, INC. HIPAA ACKNOWLEDGMENT AND CONSENT

I understand that Salem Women's Clinic (referred to below as "SWC") will use and disclose **health information** about me. I understand that my **health information** may include information both created and received by the 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, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

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

- make decisions about and plan for my care and treatment;
- 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 health care; 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 SWC 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 SWC, and my rights regarding my health information. Our Notice of Privacy Practices is also available at our website: salemwomensclinic.com. 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 understand that SWC is not required by law to agree to such requests. I authorize my personal medical information to be released to me at my:

Cell# \_\_\_\_\_ OK to leave confidential info? YES  NO

Home# \_\_\_\_\_ OK to leave confidential info? YES  NO

Work# \_\_\_\_\_ OK to leave confidential info? YES  NO

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I also authorize my personal medical information to be released to:

spouse/partner \_\_\_\_\_ @# \_\_\_\_\_

parent or other: \_\_\_\_\_ @ # \_\_\_\_\_

**By signing below, I agree that I have reviewed and understand the information above and that I have been offered a copy of the Notice of Privacy Practices.**

Patient name: _____	DOB: _____
Signature: _____	Date: _____
By: _____ (Patient representative)	Date: _____
Description of Representative's Authority: _____	