Oregon City Acupuncture
619 Madison #110 Oregon City, OR 97045
503-653-1468

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

NAME _____
BIRTHDATE _____ **OFFICE ID #** _____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

I request the following restrictions to the use of disclosure of my health information: (initial)

___Mental Health ___HIV / AIDS ___Alcohol / Drug treatment ___Other:

OR
I have no restrictions on any information to be released ____

X _____ _____
Patient signature or legal representative **Date**

_____ _____
Office signature **Date**

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I have received and read **the patient rights / HIPAA information form**. I understand the information and have asked any questions necessary regarding the information presented.

_____
Initial Date

I have received and read **the patient responsibilities form**. I understand and accept the responsibilities regarding the financial policy and scheduling / cancellation requirements. All questions regarding these policies have been answered for me.

_____
Initial Date

I consent for my practitioner Oregon City Acupuncture to consult with other health care professionals and selected relatives and care givers regarding my health care and treatments.

Appropriate persons: (family, friends, physicians, etc)

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

X_____
Patient signature **Date**