Patient Info:

GOLDEN VALLEY HEALTH CENTERS

Health Insurance Portability & Accountability Act (HIPAA)
Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by Golden Valley Health Centers for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Golden Valley Health Centers.

I understand that diagnosis or treatment of me by Golden Valley Health Centers may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations. Golden Valley Health Centers is not required to agree to the ristrictions that I may request. However, if Golden Valley Health Centers agrees to a restriction that I request, the restriction is binding with Golden Valley Health Centers.

I understand Golden Valley Health Centers uses a variety of electronic communication methods including phone, text messages, e-mail to communicate with me for the limited purposes of appointments, available services and other healthcare related communications. I authorize Golden Valley Health Centers to disclose limited protected health information to other persons who may answer my electronic communications such as phone, text messages, or e-mail. These may include information about appointments, available services, or other healthcare related communications.

I have the right to revoke this consent, in writing, at any time, except to the extent that Golden Valley Health Centers has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Golden Valley Health Centers' Notice of Privacy Practices before signing this document.

Upon request, a copy of the Golden Valley Health Centers' Notice of Privacy Practices is available to me.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Golden Valley Health Centers.

The Notice of Privacy Practices for Golden Valley Health Centers is also provided and available in the reception area and on the Golden Valley Health Centers web site at www.gvhc.org

This Notice of Privacy Practices also describes my rights and the duties of Golden Valley Health Centers with respect to my protected health information.

Golden Valley Health Centers reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised notice of privacy practices by accessing the Golden Valley Health Centers' web site, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative Date

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Name of Patient or Personal Representative

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Description of Personal Representative's Authority