SHERMAN COUNTY MEDICAL CLINIC

HIPAA

(Health Information Portability and Accountability Act)

Erin Haines, PA-C
110 Main Street
PO Box 186
Moro, OR 97039
Phone: 541-565-3325

*Patient Name:*_____ *DOB:*___/___/____

2023 Privacy Policy Acknowledgement and Consent

I understand that **Sherman County Medical Clinic** (referred to below as "SCMC") 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 SCMC 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 SCMC 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 SCMC, and my rights regarding my health information.*

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 SCMC is not required by law to agree to such requests. This Privacy Agreement is good for 2 years from date of signature.

Confidentiality issues:

Does SCMC have permission to leave messages on your "Telephone messaging machines", relating to your medical care? YES ☐ NO ☐

2. Please list anyone you authorize SCMC to share your medical information with. Examples: family member, spouse or friends

If none- please write N/A:

Name: _____ relationship to you:_____Phone#_____
Name: _____ relationship to you:_____Phone#_____
Name: _____ relationship to you:_____Phone#_____

Any additional information regarding your privacy that you would like staff to know:

_____

By signing below you acknowledge that you have reviewed and understand the information above AND that you have the right to receive a full copy of the Notice of Privacy Policy.

Patient's Signature: _____ Date: ____/_____/_____

OR

Representative's Signature: _____ Date: ____/_____/_____

Description of Representative's Authority:_____