

HIPAA PRIVACY PRACTICES CONSENT FORM

White River Rural Health Center, Inc. is committed to providing security for patient privacy and confidentiality. This organization collects, uses, and discloses personal health information only in conformance with state and federal laws and your personal authorization.

White River Rural Health Center also realizes you may have family members or significant people in your life who you may wish to have access to certain information contained in your medical record. Without your written consent, we cannot release any information to anyone except for purposes outlined in the HIPAA privacy act.

I have received a copy of the White River Rural Health Center, Inc. Notice of Privacy Practices.

I authorize White River Rural Health Center, Inc. to share my protected health information (PHI) with the following specific person(s):

(If no other person is authorized to receive your PHI, write N/A in the spaces below.)

Message Number:

Name: _____ Number: _____

Emergency Contact:

Name: _____ Number: _____

I give my permission for White River Rural Health Center, Inc. to: *(check all that apply)*

Leave a message on my answering machine or other electronic device(s) about my appointments, lab results, follow-up care, or other medical information.

Contact me at my home address and phone number.

Leave a message with the person indicated as a “message” number if I cannot be reached otherwise.

Contact my next of kin or emergency contact person in the event of an emergency.

Send me an email message at : _____.

Contact me regarding voluntary participation in a clinical research. I understand that by checking this box I am NOT obligated to participate in any specific project. Please contact me about projects by:

mail phone email address:

Print Patient Name

Date of Birth

Patient/Guardian Signature

Date