
Consent and Acknowledgement of Receipt of Notice of Privacy Practices for Purposes of Payment and Healthcare Operations **HIPAA**

I consent to the use or disclosure of my protected health information by Jordan Young Institute for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Jordan Young Institute.

I have the right to revoke this consent, in writing, at any time, except to the extent that Jordan Young Institute has taken action in reliance on this consent.

My "protected health information" (PHI) 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 Jordan Young Institutes' Notice of Privacy Practices (NPP) prior to signing this document. The Notice of Privacy Practices has been offered 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 Jordan Young Institute. The Notice of Privacy Practices for Jordan Young Institute is also provided **in the lobby** and on the group website at www.jordan-younginstitute.com. This Notice of Privacy Practices describes my rights and responsibilities and Jordan Young Institutes' duties and actions with respect to my protected health information.

Jordan Young Institute 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 group's website, calling the office and requesting a revised copy be sent in the mail, or asking for one at the time of my next appointment. I acknowledge I have been told about and offered to receive a copy of the Notice of Privacy Practices.

Release of Information: I hereby give Jordan Young Institute permission to release information on my medical condition to the following people:

(Name & Relationship)

(Name & Relationship)

(Name & Relationship)

I understand the areas discussed with these people could include treatment options, side effects, prescriptions, financial information, test results, etc.

Patient Signature or Personal Representative Signature

Date

Print Name of Patient or Personal Representative



Parent or Personal Representative
refused to sign acknowledgement

_____ Staff Initials

_____ Date

I would like to **RESTRICT DISCLOSURES** "To the Insurance Company"
for services paid for out of pocket.

Patient Signature: _____

Date of Service: _____