Cascade Direct Care HIPPA Acknowledgement

Patient Name:_____

ACKNOWLEDGEMENT AND CONSENT

I understand that Cascade Direct Care 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. My medication lists may be shared with my other providers and facilities who participate in my care. I understand and agree that Cascade Direct Care 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 for outside healthcare needs.
• perform various office, administrative and business functions that support my physician's efforts to provide me with, and arrange for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how Cascade Direct Care 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, Cascade Direct Care, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of this Practice's Notice of Privacy Practices in effect will be posted in the waiting/reception area.

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 Cascade Direct Care is not required by law to agree to such requests.

____ Individual refused or was unable to sign an acknowledgement that the individual received our Privacy Practices Notice. Describe your good faith effort to obtain the individual's signed acknowledgement and the reason you were unsuccessful on the line below:

_____

I acknowledge that I received the Cascade Direct Care Notice of Privacy Practices.

By: _____ Date:_____

(Patient's signature)

By: _____ Date:_____

(Patient representative's signature)

Description of Representative's Authority _____