**Benton Health Services**
**530 NW 27th St. • P.O. Box 579**
**Corvallis, OR 97339-0579**
**(541) 766-6835 • fax (541) 766-6186**

Name: ______________________________

Client # _____________ DOB ____________

# ACKNOWLEDGMENT AND CONSENT (HIPAA)

I understand and agree that Benton Health Services (BHS) 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 including other providers within Benton County Health Department and the Benton Community Health Center, for my care and treatment;
- Reporting suspected abuse, neglect, or domestic violence;
- 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 BHS 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 BHS will handle health information about me. This written description is known as ***Notice of Privacy Practices*** and describes the uses and disclosures of my health information; the information practices followed by the employees, staff, and other office personnel of BHS; and my rights regarding my health information.

I understand that the BHS will use and disclose health information about me. I understand that my health information may include information both created and received by BHS, 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 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 BHS Notice of Privacy Practices in effect will be posted in the waiting / reception areas as well as on the website at http://www.co.benton.or.us/health

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 BHS is not required by law to agree to such requests.

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Benton Health Services is part of an organized health care arrangement including participants in the OCHIN Network. OCHIN supplies information technology and related services to Benton Health Services and other OCHIN participants. Your health information may be shared by Benton County Health Services with other OCHIN participants of the organized health care arrangement.

**By signing below, I agree that I have reviewed the information above and that I have received a copy of the Notice of Privacy Practices.**

By: ______________________________ Date: ______________

***Patient***

*-or-*

By: ______________________________ Date: ______________

***Patient Representative***

***Description of Representative's Authority***: ______________________________