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 County Health Services (BCHS) is part of an organized health care arrangement including participants in the OCHIN Network. A current list of OCHIN participants is available at www.ochin.org as a business associate of BCHS OCHIN supplies information technology and related services to BCHS and other OCHIN participants. OCHIN also engages in quality assessment and improvement activities on behalf of its participants. For example, OCHIN coordinates clinical review activities on behalf of participating organizations to establish best practice standards and assess clinical benefits that may be derived from the use of electronic health record systems. OCHIN also participants work collaboratively to improve management of internal and external patient referrals. Your health information may be shared by BCHS with other OCHIN participants when necessary for health care operations purposes of the organized health care arrangement. Health care operation can include among other things, geocoding your residence location to improve clinical benefits you receive.

The personal information may include past, present and future medical information as well as information outlined in the Privacy Rules. The information, to the extent disclosed, will be disclosed consistent with the Privacy Rules or any other applicable law as amended from time to time. You have the right to change your mind and withdraw this consent, however, the information may have already been provided as allowed by you. This consent will remain in effect until revoked by you in writing. If requested, you will be provided a list of entities to which your information has been disclosed.

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: _____