



HIPAA (Health Insurance Portability & Accountability Act of 1996) ACKNOWLEDGEMENT AND CONSENT

I understand that ORegon Surgery Center referred to below as ORSC will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by ORSC, 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 and agree that ORSC 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, 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 my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

A detailed **Notice of Privacy Practices** that describes the uses and disclosures of health information and the practices followed by ORSC staff and my rights regarding my health information is posted in waiting/reception area of ORSC for my perusal. 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 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 ORSC is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I can have upon request a copy of the Notice of Privacy Practices.

By: _____ (Patient)	Date: _____
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-OR-

By: _____ (Patient representative)	Date: _____
Description of Representative's Authority: _____	