HALEIWA FAMILY HEALTH CENTER

Patient Consent Form

By signing this form, you are granting consent to Haleiwa Family Health Center to use and disclose your protected health information for the purpose of treatment (including medication history), payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting Jan Lerner, Office Administrator, 66-125 Kamehameha Hwy., Haleiwa, HI 96712-1420, Phone: 637-5087. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Signature:_____ Print name:_____

Date:_____

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I,_____, have received a copy of Haleiwa Family Health Center's Notice of Privacy Practices.

Signature of Patient/Parent:_____

Print Name:_____ Date:_____