# OLYMPIC PSYCHIATRIC CARE

## HIPAA CONSENT FORM

The Health Insurance Portability & Accountability Act (HIPAA) allows for the use of certain protected health information for treatment, payment or healthcare operations.

Under the HIPAA act, this information can be used to:

- Conduct, plan and direct treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and provider certifications.

You have the right to request that we restrict how protected information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

You may also designate persons with whom we are allowed to discuss and/or disclose your personal health information (PHI).

Please tell us with whom we are allowed to discuss and/or disclose your PHI.

Name: Relationship:
Name: Relationship:

☐ I do not wish to designate any persons with whom my personal health information can be shared.

The terms of this notice may change as allowed by law. If so, you will be notified at your next visit to update your signature and date.

A more complete description of the uses and disclosures of patient health information is included in our Notice of Privacy Practices, which is posted in our office.

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I have read and understand Olympic Psychiatric Care's privacy practices as outlined in the Notice of Privacy Practices.

I consent to the use and disclosure of protected health information about me for treatment, payment, and health care operations.

I understand I have the right to revoke this consent in writing, signed by me, and that such a revocation will not be retroactive.

Signature:_____ Date:___/___/_____

Print Name:_____