DESCHUTES RIM
HEALTH CLINIC

HIPAA Acknowledgement and Consent

_____ _____

Patient Name Date of Birth

I understand that my health information may include information both created and received by Deschutes Rim Health Clinic (DRHC), that it may be in the form of written or electronic records or spoken words, and may include information about my health and mental health history, health status, symptoms, examination, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that DRHC may use and disclose my health information for:

- Making decisions about and planning for my care and treatment (including activities performed by a physician, nurse practitioner, or other healthcare provider directly delivering care at DRHC).
- Referring to, consulting with, coordinating with, and managing along with other healthcare providers my care and treatment.
- Determining my eligibility for health plan or insurance coverage, submitting bills, claims, and other related health information to insurance companies or others who may be responsible for paying for some or all of my healthcare.
- Performing various office, administrative and business functions that support my Provider's efforts to provide me with, arrange, and be reimbursed for quality, cost effective healthcare.

I also understand that I have the right to receive and review a written description of how the health clinic will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made, the information practices followed by the employees, staff, and other office personnel of DRHC, and my right regarding my health information.

I understand that I have the right to ask that some or all my health information not be used or disclosed in the manner described in the Notice of Privacy Practices.

By signing below, I agree that I have received, reviewed, and understand the information above. I understand I have the right to revoke this consent in writing, except to the extent that has already been used or information disclosed in reliance on this consent.

_____ _____ _____

Patient (or Representative) Signature Representative Name Date

I authorize DRHC to discuss my medical information with the following:

Name: _____ Relationship:_____ Phone: _____

Name: _____ Relationship:_____ Phone: _____

Name: _____ Relationship:_____ Phone: _____

Revised 09/2025