JERSEY COMMUNITY HOSPITAL HIPAA CONSENT

I, ______________________________, understand that as part of my health care, Jersey Community Hospital and the physician(s) who care for me originate and maintain health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among health professionals who contribute to my care.
- A source of information for applying my diagnosis and treatment information to my bill.
- A means by which a third-party payer, including Medicare and Medicaid, can verify that services billed were actually provided.
- A tool for routine health care operations, such as assessing quality and reviewing the competence of health care professionals.

I understand and have been provided with a ***Notice of Health Information Practices*** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations. I further understand that Jersey Community Hospital is not required to agree to the restrictions requested.

Requested restrictions: ____
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I understand if I choose to pay for my services privately that I may instruct my health care provider(s) to not share information about my treatment that I received with my health plan carrier.

I understand that Jersey Community Hospital reserves the right to change its notice and practice in accordance with Section 164.520 as described in the Code of Federal Regulations.

I have been informed that if I refuse to sign this consent for the use and disclosure of my health information, Jersey Community Hospital may refuse to admit or treat me in any manner in accordance of Section 164.506 of the Code of Federal Regulations.

I understand that I have the right to revoke this consent in writing, except to the extent that Jersey Community Hospital has already taken action in reliance thereon. I understand that if I revoke my consent, then Jersey Community Hospital will no longer be able to treat me, and that I will need to be discharged from the facility.

I understanding that as part of this hospitals treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax or secured email.

I fully understand and **ACCEPT** the terms of this consent.

______________________________________ ______________________________________
(Signature) **(Date)** **(Witness)** **(Date)**

If the authorizing signature is not that of the patient, indicate legal relationship to the patient or legal basis on which consent is given for the patient (i.e. parent, legal guardian, etc.) __________________________

Revised 3/2014