Tuscarawas County Health Department Acknowledgement of Notice of Privacy Practices

Patient Name: ___________________________________ Date of Birth: ____________________

I authorize Tuscarawas County Health Department employees to leave a detailed message regarding the following information: appointment reminders, insurance/financial issues, and/or any other information regarding my care/treatment.

_______YES _______NO

Disclosures to Authorized Individuals

I designate the following person(s) listed below as a person or persons involved with my health care and/or payment for my health care (indicate as applicable), to whom the information indicated "yes" below may be released:

Name	Relationship	Phone Number	Health Information	Payment Information	Can we leave a detailed message with this individual?
			YES or NO	YES or NO	YES or NO
			YES or NO	YES or NO	YES or NO
			YES or NO	YES or NO	YES or NO

I understand the following:

- That the requested information may contain information regarding physical and mental illness, HIV test results or diagnosis, AIDS, or AIDS related conditions, alcohol and/or drug dependence/abuse. I also understand that information used or disclosed according to this authorization may be subject to re-disclosure by the recipient and may no longer be protected.
- This authorization is effective for the above requested and authorized health care information only. You may ask for and receive a copy of this authorization form if requested in writing.
- This authorization will expire on the date you indicated below. Additionally, you may revoke this authorization at any time by submitting a written request.
- You have a right to inspect any information you are authorizing to be re-released.
- The information you are authorizing to be released could be re-released or disclosed by the recipient. We are not responsible for the actions of others who may be provided with information because of this authorization.
- You may refuse to sign this authorization. Your refusal to sign will not affect your service.
- There may be a fee associated with the copying of your records and accept responsibility for those charges.
- I understand that TCHD shall not condition treatment, payment or enrollment in the health plan or eligibility for benefits on my providing authorization for the requested use or disclosure and that I MAY REFUSE TO SIGN THIS AUTHORIZATION.
- The health care providers listed above will not receive financial or in-kind compensation in exchange for using or disclosing my health care information.

This authorization is effective now and will remain in effect until (date): ____________________

Failure to specify an expiration date will result in this authorization expiring one (1) year from date of signature.

I hereby acknowledge that I have received from the Tuscarawas County Health Department Medical Clinic a copy of its Notice of Privacy Practices. I understand that the Notice of Privacy Practices sets forth my rights relating to the use and disclosure of my personal health information and explains how the Tuscarawas County Health Department may use and/or disclose my personal health information both with and without my authorization. I further understand that I may contact the Compliance Officer if I have any questions regarding the contents of this Notice of Privacy Practices or to file a complaint about the privacy practices of the Tuscarawas County Health Department's Medical Clinic.

___________________________________ _____________________________________ _______________________

Signature of Patient/Parent/Legal Guardian **Printed Name** **Date**

REVOCATION: ONLY FILL OUT IF YOU ARE NOT CONSENTING TO THE ABOVE OR DECIDE TO REVOKE THIS CONSENT.

This authorization is subject to revocation at any time except to the extent the program or person who is to make the disclosure has already acted in reliance on it.

I hereby revoke my consent on (date)_________ Signature of Patient/Parent/Legal Guardian: ____

FOR REPRODUCTIVE PATIENTS WHO WISH TO BE A NO CONTACT-ONLY PLEASE PROVIDE US THE FOLLOWING:

Mailing Address: ____

If we mail information to you at the address provided above, which do you prefer.

_______Tuscarawas County Health Department logo on envelope and letterhead

_______Plain Envelope and letterhead

11/8/2023ak;11/9/23ak