



Kartini Clinic, P.C.

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Phone (503) 249-8851 Fax (503) 282-3409
www.kartiniclinic.com

Office Use Only
HIPAA Expiration Date
Entered into Centricity:
Initials: _____

5 - ACKNOWLEDGEMENT AND CONSENT (HIPAA)

I understand Kartini Clinic, (referred to below as “This Practice”) will use and disclose health information about me.

I understand that my health information may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice **may use and disclose my health information** in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support my physician’s efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a Notice of Privacy Practices¹ and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices at my request. I also understand that a copy or a summary of the most current version of This Practice’s Notice of Privacy Practices is available in the waiting area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

BY SIGNING BELOW, I AGREE THAT I HAVE REVIEWED AND UNDERSTAND THE INFORMATION ABOVE.

Date Signature of patient representative (if patient is less than 18 years of age or in the case of medical guardianship)

Printed Name Description of authority

OR

Date Signature of patient (if over 18 years of age) Printed Name

¹ “Notice of Privacy Practices” document is located: \\kartiniser\public\Front Office\HIPAA\Notice of Pt Privacy 6-25-09.doc