

Knox County Health Department

Privacy Agreement

Patient's Name: _____

Medical Record Number: _____

Date of Birth: _____

I understand that as part of my healthcare, Knox County Health Department creates and maintains health records that identify me by describing my health history, symptoms, examination, and test results, diagnoses, treatment, and any plans for future care or treatment. I consent to the use or disclosure of my protected health information, and I understand that this information serves as:

1. a basis for planning my care and treatment
2. a means of communication among the many health providers who contribute to my care
3. a means to contact me by using the contact method(s) provided by me for appointment reminders, information about disease management, wellness programs, prescription refill reminders, and other communications regarding my case management or health care condition
4. a means to notify me of other treatment or services available that might help me
5. a source of information for applying my diagnosis and medical information to my bill
6. a means by which a third-party payer (insurance company, etc.) can verify that services billed to them were actually provided by Knox County Health Department
7. a tool for routine healthcare operations such as assessing quality of service, and reviewing the competence of healthcare professionals

I have been provided with, and understand, a Notice of Privacy Practices that provides a more complete description of information uses and disclosures of my personal healthcare information.

1. I understand that I have the right to review the notice prior to signing this consent.
2. I understand that Knox County Health Department reserves the right to change their notice. However, prior to implementing any change the Health Department will post a revised copy in the clinics of the Health Department and post the revised notice on their website.
3. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations of Knox County Health Department. If the restrictions are accepted by the Health Department, they are binding.
4. I understand that the Knox County Health Department is not required to agree to the restrictions requested.

I understand that I may revoke this consent, except to the extent that Knox County Health Department has already taken action while relying on this consent. I understand that if I revoke my consent, it must be in writing.

I request the following restrictions to the use of disclosure of my health information: None **OR AS FOLLOWS:**

Signature of Patient / Legal Representative / Date: _____

Relationship to Patient: _____

Since the patient is unable to read this document, I have explained the material verbally and answered his/her questions.

Signature, KCHD / Date: _____

RESTRICTIONS:

Accepted

Denied

Signature, KCHD Management / Title / Date