Lower Lights
Christian Health Center

Privacy Practices – Patient Consent

I have read and understand the Privacy Practices given to me and give my permission for LLCHC to use my protected health information (PHI) for the following purposes:

Consent for treatment: I give my permission for LLCHC physicians and employee working under the direction of the physician to provide medical care for me or to the patient for which I am a legal guardian. This may include services and supplies related to my health and may include (but not limited to) preventive, diagnostic, therapeutic, maintenance, palliative care, counseling, assessment or review of physical or mental status/function, and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent is applicable to both in-person visits and telehealth visits. This consent includes contact and discussion with other health care professionals. I understand that LLCHC participates in one or more Health Information Exchanges and may use this to search for and access health information to provide better quality care. I understand that by signing this form I agree that LLCHC, and other health care providers, may search for, access and share my health information.

Consent for release of information for payment/operations and assignment of benefits: I also agree to allow LLCHC to send my information to the identified insurance carrier(s) for any and all payment activities. I consent to assign all payments for services rendered. I understand that I am responsible for all co-payments, amounts applied to deductibles and other amounts that may be deemed my responsibility by payor sources, as required by my contract with my insurance plan and state regulations. It is my responsibility to obtain all information from my health plan about coverage for services and if I seek care outside of the contract I am responsible for all charges incurred. I understand that my information may also be used for any operational needs as described in the Notice of Privacy Practices.

Consent for the Privacy Practice Notice: I agree that during my registration process I had the chance to read the Privacy Practices Notice. I understand these terms may change and that at any time I may request a copy of these practices by phone or in writing. I understand I have the right to know how my information is used and can also restrict how my information is shared. LLCHC is not required to agree to my restrictions but if an agreement is met then LLCHC is bound to the agreement.

Lower Lights Christian Health Center is part of an organized health care arrangement including participants in OCHIN. A current list of OCHIN participants is available at www.OCHIN.org. As a business associate of Lower Lights Christian Health Center, OCHIN supplies information technology and related services to Lower Lights Christian Health Center and other OCHIN participants. OCHIN also engages in quality assessment and improvement activities on behalf of its participants. For example, OCHIN coordinates clinical review activities on behalf of participating organizations to establish best practice standards and access clinical benefits that may be derived from the use of electronic health record systems. OCHIN also helps participants

work collaboratively to improve the management of internal and external patient referrals. Your health information may be shared by Lower Lights Christian Health Center with other OCHIN participants when necessary for health care operation purposes of the organized health care arrangement.

I understand that LLCHC may refuse to provide services if I do not agree to these conditions. I may revoke this consent in writing at any time, but LLCHC may then refuse to provide services. If I choose to revoke this consent, it will take effect once LLCHC receives it in writing.

Patient/Guardian _____ Date _____

Printed Name _____ Relationship (if not patient) _____

Patient unable to sign due to _____

REVOCATION OF CONSENT: I hereby revoke the consent given above.

Patient/Guardian _____ Date _____

Printed Name _____ Relationship (if not patient) _____