Lifespan HEALTH
HARDIN COUNTY REGIONAL HEALTH CENTER

PATIENT CONSENT & HIPAA INFORMATION

PLEASE PROVIDE THE RECEPTIONIST WITH A PHOTO ID & YOUR INSURANCE CARD(S)

(Legal) Last Name:	First Name, Middle Initial:	Date of Birth:

PATIENT AUTHORIZATION TO BILL & HIPAA DISCLOSURE

☐ I authorize that payment of authorized insurance benefits be made to LIFESPAN HEALTH for services furnished to me. I authorize LIFESPAN HEALTH to release to my insurance carrier and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that I will be directly responsible for any portion deemed patient liability by my insurance carrier. I further acknowledge the below signature to be mine and to be used as my "Signature on File" for eletronic billing purposes. I understand this signature will be used indefinitely unless I revoke this arrangement.

☐ I acknowledge that I am a "self-pay patient" and as such will be responsible for all services rendered to me. I understand I may qualify for patient assistance but this assistance is in no way guaranteed.

☐ I hereby acknowledge that I was provided with LIFESPAN HEALTH's Notice of Privacy Practices.

☐ I hereby authorize LIFESPAN HEALTH to release my Protected Health Information to the following individuals:

Name	Relationship	Telephone

☐ I do not wish my Protected Health Information released to anyone.

CONSENT TO TREATMENT & TO OBTAIN ELECTRONIC MEDICATION HISTORY

☐ I request and authorize treatment and services as may be deemed necesary and appropriate by the providers of LIFESPAN HEALTH. this care may include radiology, laboratory, x-ray, etc.

☐ I authorize LIFESPAN HEALTH to obtain my medication history utilizing an electronic information exchange. I further authorize LIFESPAN HEALTH to transmit, view, and disclose this information as part of my medical record and treatment.

CONTACT PREFERENCES: I wish LIFESPAN to adhere to the following contact preferences:

Home Phone:
- ☐ Ok to leave detailed information
- ☐ Leave only a call back number

Work Phone:
- ☐ Ok to leave detailed information
- ☐ Leave only a call back number

Written Communication:
- ☐ Ok to send information to my home address
- ☐ Do not send anything to my work address
- ☐ OK to send anything to my work address
- ☐ Only send mail to my home address
- ☐ OK to send my an e-mail: _____

Pt. Signature:	Date:

We attempted to obtain written acknowledgement of reciept of our Authorization to Release PHI, but it could not be obtained for the following reasons: ____ Individual refused to sign ____ Communication barriers prohibited obtaining the acknowledgement ____ An emergency situation prevented us from obaining acknowledgement ____ Other (Please Specify) _____

Staff Representative Signature Date