HIPAA Acknowledgment

I understand that my **health information** may include information both created and received by The Portland Clinic, 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, tests results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand that The Portland Clinic 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 provided me with, arrange, and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive a written description of how The Portland Clinic will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff, and other office personnel of The Portland Clinic, and my rights regarding my health information as defined under the Health Insurance Portability and Accountability Act (HIPAA).

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. I also understand that a copy or a summary of the most current version of The Portland Clinic's Notice of Privacy Practices in effect will be posted in waiting/ reception area and available on the website at www.theportlandclinic.com.

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 The Portland Clinic is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

By: ____________________________________ **Date:** ________________
(Patient)

By: ____________________________________ **Date:** ________________
(Patient Representative)

Description of Representative's Authority: ____________________________________

- Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-503-221-0161.
- Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-503-221-0161.

7655 (7/19)