WAKE HEALTH SERVICES
A Community Health Center

## HIPPA AUTHORIZATION / ACKNOWLEDEMENT

## PLEASE READ THIS ENTIRE PAGE AND RESPOND AS DESIRED

I acknowledge receiving ***Wake Health Services, Inc.***'s Notice of Privacy Practices. I understand that ***Wake Health Services, Inc.*** may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that ***Wake Health Services, Inc.*** will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in ***Wake Health Services, Inc*** 's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____ _____ _____
Patient/Guardian Name Patient/Guardian Signature Date

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I authorize Wake Health's staff and providers to leave messages at my home telephone number ❑ YES ❑ NO

I authorize Wake Health's staff and providers to leave messages at my work telephone number ❑ YES ❑ NO

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I authorize Wake Health's staff and providers to send mail to my home address ❑ YES ❑ NO

I would prefer to receive mail from Wake Health's staff and providers at the following address: _____

_____

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I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

_____ _____
Patient Signature Date

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I also authorize ***Wake Health Services, Inc.*** to use my protected health information for targeted marketing, fund raising, and/or solicitation of participation in research studies. I understand I have the right to copy or inspect any information used for these purposes. I also understand this authorization does not affect my consent to use my protected health information for treatment, billing, or operations related to treatment and billing.

_____ _____
Patient Signature Date

_____ _____ _____
Witness Name Witness Signature Date

Updated 04/2009