_____
Name of Patient

KEARNEY COUNTY HEALTH SERVICES
Minden Medical Clinic

_____
Date of Birth

HIPAA

Please choose *ONLY ONE* option below:

Option 1: Giving Permission

_____ **I hereby give permission to discuss my protected health information (PHI) with the following individuals** *(Please fill in the name of the individual):*

Spouse: _____

Children: _____

Other family members: _____

Friends: _____

Clergy: _____

Other: _____

_____ _____
Patient Signature Date Signed

_____ _____
Patient Legal Representative Signature Date Signed

_____
Relationship of Legal Representative to Patient

Option 2: Acknowledgement

I am aware of the Notice of Privacy Practices at Kearney County Health Services. I understand that I may or may not choose to read the Privacy Practices.

_____ **I choose to keep my protected health information confidential**

_____ _____
Patient Signature Date Signed

THIS FORM IS EFFECTIVE FOR TWO YEARS