HIPAA

____ Name of Patient

______________________ Date of Birth

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

____ Signature

______________________ Date

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