



KEARNEY COUNTY HEALTH SERVICES

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www.kchs.org

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