Jericho Road Community Health Center
Administrative Offices: 184 Barton Street, Buffalo, NY 14213
Phone: 716.881.6191
www.jrchc.org

Health Insurance Portability & Accountability Act (HIPAA) Consent Form

New York State law prohibits Jericho Road Community Health Center (JRCHC) staff from speaking with anyone other than you regarding any of your medical health information. This includes information about your condition, medication, appointments or test results. Patients have the right to privacy and confidential records. You have the right to give permission so that Protected Health Information (PHI) may be shared so that our office can carry out your treatment, collect payment and carry out health care operations (Treatment, Payment or Healthcare Operations). Jericho Road Community Health Center's [Notice of Privacy Practices & Policy] explains with more detail of the law and health information sharing practices. Patients have the right to view this notice and copies are available in our office.

Jericho Road Community Health Center will need your permission to be able to call your home with messages about health information and appointments. We will also need your permission to speak about your health information with anyone else. We will observe you sign this form which will show that you understand this information and give permission.

_____ _____
PRINT PATIENT NAME (AND GUARDIAN NAME IF APPLICABLE) **PATIENT DATE OF BIRTH**

I give my permission for Jericho Road Community Health Center to use and share my personal health information to carry out Treatment, Payment or Healthcare Operations. With this permission, Jericho Road Community Health Center may mail items or call my home (or other locations I list) to help carry out Treatment, Payment or Healthcare Operations. They may leave messages about healthcare information, (such as, appointment reminders, payment questions and clinical care) on voicemail, message machines and with others who answer my phones.

You may also allow another person(s) to be able to discuss your Personal Health Information on your behalf (such as a spouse, partner, relative or friend). List the name(s) of persons you allow JRCHC to speak about your Personal Health Information (print names and relationships):

_____

_____

JRCHC may speak with the above named person(s) about any of my health information, including, but not limited to clinical information, health advice and treatment, appointments, and payment information.

I have read and understood all of the above information.

_____ _____
SIGNATURE OF PATIENT OR REPRESENTATIVE/GUARDIAN **DATE**

_____
SIGNATURE OF WITNESS