

**Wasilla Medical Clinic**  
**NOTICE OF PRIVACY, CONSENT, AND HIPAA**

I understand that under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

**Release for Protected Health Information:**

Indicate any persons authorized to discuss your Protected Health Information with our office or our billing office. Include the person’s name and relationship to yourself. Include a start date and an end date to set restrictions for any individual(s).

Name	Relationship	Start Date	End Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Patient Name Print: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian Signature if minor child: \_\_\_\_\_ Date \_\_\_\_\_