BHFS Medical & Behavioral Services
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HIPAA RELEASE FORM AND ACKNOWLEDGEMENT

PRIVACY OF PROTECTED HEALTH INFORMATION

Federal and state laws require us to maintain the privacy of your health information and to give you this notice about our privacy practices, our legal duties, and your rights concerning your Protected Health Information (PHI).

BHFS Medical & Behavioral Services reserves the right to change our privacy practices and the terms of this notice at any time, law permitting. You may request a copy of this notice at any time.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

We may use and disclose your protected health information in the following circumstances:

- **To physicians, dentists and health care providers who are taking care of you and are a part of your health care team either through direct care or consultation.**
- **To obtain payment of services we provide to you.**
- **In connection with our healthcare operations such as quality improvement activities, evaluating physician and health care provider competency, conducting training and educational activities, licensing, credentialing, accreditation or certification activities.**
- **When you give us written authorization to disclose your PHI to anyone for any purpose other than treatment, payment and healthcare operations. You may revoke this authorization in writing at any time.**
- **Revoking any authorization only affects uses or disclosure AFTER the date of your written notice.**
- **To you, and any family members, friends or others you authorize, to get help with making healthcare decisions and paying for your care.**
- **To notify or assist in notifying a parent, guardian or other person responsible for your care about your location, general condition, illness or death. If you are present and able to consent/not consent, we will allow you the opportunity to do so.**

I acknowledge that I have read this Notice, understand what it says, and I was given an opportunity to ask questions.

Patient(s) Printed Name:_____

Patient(s) DOB:_____

Signature (parent/guardian if patient is a minor)_____

Relationship to patient: _____

Date_____