



Acknowledgement & Consent

- Acknowledgement by Individual of Receipt of the Notice of Privacy Practices
Consent by Individual to the Use/Disclosure of the Individual's Protected Health Information for Treatment, Payment or Operations as set forth in the Notice of Privacy Practices

I have received the Notice of Privacy Practices for Stanly Health Services.
I consent to the use or disclosure of my health information as outlined in that Notice.

I understand that I have the right to review the Notice prior to signing this form for a description of the potential uses and disclosures by SHS of such information.

SHS reserves for itself the right to change the terms of its Notice of Privacy Practices for Protected Health Information at any time. If SHS does change the terms of its Notice of Privacy Practices, individual may obtain a copy of the revised Notice at the next occasion of treatment or earlier upon written request to the SHS Privacy Officer.

I understand that an individual retains the right to request that SHS further restrict how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. SHS is not required to agree to such requested restrictions; however, if SHS does agree to an individual's requested restriction(s), such restrictions are then binding on SHS.

At all times, I understand that an individual retains the right to revoke consent; however, such revocation must be submitted to the SHS Privacy Officer in writing. The revocation shall be effective when properly submitted except to the extent that SHS has already taken action in reliance on the consent. SHS may refuse to treat an individual if the individual or an authorized representative does not sign this Consent Form (except to the extent that SHS is required by law to treat individuals). I understand that if I or my authorized representative sign this Consent Form and then revoke Consent, SHS has the right to refuse to provide further treatment as of the time of revocation (except to the extent that SHS is required by law to treat individuals).

I am the individual named below, or I am authorized to act on behalf of the individual to consent and to sign this sealed document. I have read and understand the information on this form.

Individual or Representative Signature Date Time

Print Name

Witness Signature Date Time

Print Name

Describe Representative's Authority to Act on Behalf of Individual (Attach Copy of Any documentation of Representative's Authority)

