Bright Eyes MIDWIFERY & Wild Rivers WOMEN'S HEALTH CLINIC, LLC
PO Box 1710
Gold Beach, OR 97444
T: 541.425.5311
F: 541.425.5577

HIPAA PATIENT CONSENT

Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. The notice contains a Patient Rights section describing your rights under law. You have the right to review our notice before signing this consent. The terms of our practice's notice is subject to change at any time. If we change our notice, you may obtain a revised copy through our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or healthcare operations. We are not required to agree to this restriction, but if we do, we shall honor the agreement made.

By signing this form, you consent to our use and disclosure of your protected health information. You have the right to revoke this consent, in writing and with your signature. However, revoking it will not affect any disclosures we have already made in reliance to your prior consent. Our practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I, _____, understand that my health information may be disclosed for treatment, payment or health care operations.

I understand that Bright Eyes Midwifery and Wild Rivers Women's Health, LLC has a Notice of Privacy Practices and I have the opportunity to review this notice. I acknowledge that the practice reserves the right to change this practice at any time.

I have the right to request the restriction of my health information, but the practice is not required by law to honor such a request.

I may revoke this consent in writing at any time, and all future disclosures will then cease.

I understand the practice may condition receipt of treatment upon the execution of this consent.

I acknowledge that I have been offered and received a copy of our HIPAA practices brochure.

Signature: _____

Relation to patient if other than self: _____

___ Unable to sign because: _____

___ Refused

Witness: _____
Date: _____