GUILFORD COUNTY DEPARTMENT OF PUBLIC HEALTH
COMPLIANCE PLAN: HIPAA ACKNOWLEDGMENT & CONSENT

-_____ _____
Last Name **First Name** **MI**

ACKNOWLEDGMENT/CONSENT TO USE
and
DISCLOSE PATIENT HEALTH INFORMATION

PATIENT SS#: _____

Date of Birth: ____/____/____

I, _____, acknowledge that I received a copy of the Guilford County Department of
(please print your name)

Public Health **Notice of Privacy Practices** and understand that I may contact **Tisha Adams** if I have questions about the content of the notice.

Patient/Parent/Legal Guardian Signature: _____

Date: _____

Witness Signature: _____

Date: _____

I give my voluntary consent for the Guilford County Department of Public Health to use and disclose my health/medical information for purposes of treatment, payment and health care operations.* I understand that the health/medical information used and disclosed may include information about communicable diseases (such as HIV). I understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it. I understand that this consent is valid until I revoke it and that if I want to revoke this consent I must do so in writing.

* See our "Notice of Privacy Practices" for explanations of the terms "treatment," "payment," and "health care operations."

_____ _____
Signature of Patient Date

_____ _____
Signature of parent, legal guardian, or other legally responsible person (when required) Date

_____ _____
Witness Date

REVOCATION OF CONSENT TO USE and DISCLOSE
PATIENT HEALTH INFORMATION

I do hereby request that my voluntary consent for the Guilford County Department of Public Health to use and disclose my health/medical information for purposes of treatment, payment and health care operations signed by me on _____ be rescinded, effective _____.
(Enter Date of Signature)

I understand that any action taken on this consent prior to the rescinded date is legal and binding.

_____ _____ _____ _____
(Signature of Patient) *(Date)* *(Signature of Witness)* *(Date)*

_____ _____ _____
(Signature of Personal Representative) *(Date)* *(Personal Representative Relationship/Authority)*