Prema Health
2305 SE 50th Ave, Suite 200
Portland, OR 97215

HIPAA Notice of Privacy Practices and Consent/Written Acknowledgement

I hereby consent to the use and disclosure of my protected health information by Prema Health for the purposes of treatment, payment and healthcare operations, or as otherwise required by law.

- I acknowledge that I have a right to review or receive a printed copy of the Notice of Privacy Practices provided by Prema Health prior to signing this consent. The Notice of Privacy Practices describes how medical information about me may be used and disclosed, and how I can access this information.
- I have the right to request restrictions to the usage and disclosure of my protected health information.
- I have the right to request an alternative to the standard method of communication of my protected health information.
- I understand that if I wish to revoke this consent at any time I will do so in writing and submit to the address listed below. I understand that Prema Health may honor these requests, they are not required by law to do so. I also understand that revocations will be honored as of the date they are received by Prema Health at the following address:

  2305 SE 50th Ave, Suite 200
  Portland, OR 97215

- I understand that if I have any questions or complaints I may submit them in writing to the address above or contact Prema Health by phone at: 971-407-3428.
- I am aware that Prema Health reserves the right to change the terms of their Notice of Privacy Practices and to make new notice of Privacy Practices provisions effective for all protected health information that they maintain. In the event of amendments, Prema Health will make available a revised Notice of Privacy Practice for my review.

_____ _____
Patient (18 years or older) Date

_____ _____
Parent, Guardian, Responsible Party Date

THIS SECTION IS TO BE COMPLETED BY PREMA HEALTH IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGEMENT FROM PATIENT

I made a good faith effort to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

[ ] Patient declined to sign this Written Acknowledgement
[ ] Other (specify):

_____ _____
Name and title of employee Date

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PERSONAL IDENTIFICATION INFORMATION

Please be aware that you do NOT have to provide your social security number as a form of personal identification to receive health care, UNLESS you are requesting us to bill your medical insurance carrier who requires your social security number for claim billing/reimbursement processes.

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I have fully read and understand the above terms for personal identification information.

_____ _____

Patient (18 years or older) Date

_____

Parent, Guardian, Responsible Party Date