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 I've been told that I may contact **Tisha Adams** if I have questions about the content of the notice.

Patient/Parent/Legal Guardian 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 have been told and my questions have been answered that the health/medical information used and disclosed may include information about communicable diseases (such as HIV). I have been told that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it. I have been told 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."

_____ _____
Patient/Parent/Legal Guardian Signature: **Date**

_____ _____
Witness **Date**