# ACKNOWLEDGMENT AND CONSENT

I understand that James Reavis, LCSW will use and disclose health information about me. I understand my health information may include information both created and received, may be in the form of written or electronic records or spoken works, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that James Reavis, LCSW may use and disclose health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support my practitioner/provider's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how James Reavis, LCSW will handle health information about me. The written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made, the information practices followed by James Reavis, LCSW and my rights regarding my health information. I understand that the Notice of Privacy practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of Privacy Practices in effect will be posted in the waiting/reception area at 1012 SW King Ave, Portland, Oregon.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices and I understand that James Reavis, LCSW is not required by law to

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agree to such requests. The official web site of HIPAA is: **http://www.hhs.gov/ocr/privacy/index.html.**

I authorize James Reavis, LCSW to provide notice to me by telephone or verbally in the event of a breach of my protected health information (PHI) by James Reavis, LCSW. Such conversation shall be documented by James Reavis, LCSW. Pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA) Final Rule modifying the HIPAA Privacy, Security, Enforcement and Breach Notification Rules, the verbal or telephonic notice provided to me pursuant to this authorization shall not be simply for the administrative convenience of James Reavis, LCSW.

**By signing below, I agree that I reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.**

_____ _____

(Patient) Date

**-OR-**

_____ _____

(Patient Representative) Date

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