Kearney County Health Services
Patient Consent Form
for Use and Disclosure of Protected Health Information

I hereby give my consent for Kearney County Health Services (KCHS) to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). ***The Notice of Privacy Practices contained in the KCHS Health Information Management Plan provided by KCHS describes such uses and disclosures more completely.***

I have been informed; I have the right to review the KCHS Notice of Privacy Practices prior to signing this consent. KCHS reserves the right to revise its Notice of Privacy Practices at any time. A revised KCHS Notice of Privacy Practices may be obtained by forwarding a written request to Director of Health Information Management, Kearney County Health Services, 727 East First Street Minden NE 68959.

With this consent, KCHS may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist KCHS in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, KCHS may mail to my home or other alternative location any items that assist KCHS in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, KCHS may e-mail to my home or other alternative location any items that assist KCHS in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that KCHS restrict how it uses or discloses my PHI to carry out TPO. KCHS is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow KCHS to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that KCHS has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, KCHS may decline to provide treatment to me.

______________________________	______________
Patient's Signature	Date Signed
______________________________	______________
Parent/Guardian's Signature	Date Signed
______________________________	______________
KCHS Staff's Signature	Date Signed