Washington Township
Medical Foundation
Part of Washington Hospital Healthcare System

NOTICE OF PRIVACY PRACTICES

Acknowledgement of Receipt of Privacy Notice
& Consent of Disclosure

(For the Usage and/or Disclosure of Protected Health Information)

By signing this form, you are acknowledging that Washington Township Medical Foundation has given you a copy of our Notice of Privacy Practices, which explains how your health information will be handled in various situations. You also acknowledge that Washington Township Medical Foundation has given you the chance to discuss your questions and concerns about the privacy of your health information. We must try to have you sign this form on your first date of service with us after April 14, 2003. If your first date of service with us was due to an emergency, we must try to give you this notice and get your signature acknowledging receipt of this notice as soon as we can after the emergency.

You are also giving consent to Washington Township Medical Foundation and all health care providers furnishing care with Washington Township Medical Foundation, to use and disclose your protected health information for the purposes of treatment, payment and health care operations. You may cancel this consent at any time. Your cancellation must be in writing, signed by you or on your behalf, and delivered to the address listed below. This may be delivered in person or by mail, but it will only be effective when we actually receive it. Your cancellation will not be effective to the extent that others we have acted in reliance upon this consent.

You have the right to request restriction on the usage and disclosure of your protected health information for the purposes of treatment, payment or health care operations. We are not required to grant your request, however, if we do, the restriction will be obligatory to us. Our posted Notice of Privacy Practices provides more detailed information about the usage and disclosure of your protected health information. You have the right to review our Notice of Privacy Practices before you sign this consent. We reserve the right to amend the terms of our posted Privacy Policy. You may obtain a copy of the current policy by contacting our office at **(510) 248-1000**, or visiting our web site at **www.mywtmf.com**.

Notice to Consumers

Medical doctors are licensed and regulated by the Medical Board of California
(800) 633-2322 • www.mbc.ca.gov

I understand that the physicians of Washington Township Medical Foundation are licensed and regulated by the Medical Board of California.

Physician Assistants are licensed and regulated by the Physician Assistant Committee
(916) 561-8780 • www.pac.ca.gov

I understand that the physician assistants of Washington Township Medical Foundation are licensed and regulated by the Physician Assistant Committee.

Date:____________________

Patient Name:________________________________ Signature:____________________________

If you are signing as the patient's representative:

Print Your Name:_____________________________ Relationship:__________________________

REQUEST FOR RESTRICTION ON USES AND DISCLOSURES OF HEALTH INFORMATION BY WASHINGTON TOWNSHIP MEDICAL FOUNDATION

Patient Name: ____ Date of Request: ___________

Patient Date of Birth:___________________

❑ I give permission for Washington Township Medical Foundation to disclose my health information to the following family members, friends or other people involved in my care:

Name: Relationship:

a. ____

b. ____

c. ____

d. ____

e. ____

You have the right to ask us to restrict or disclose medical information we make to those family members or others involved in your care or involved in payment for your care or for notification purposes. We are not required to agree to your request. If we do agree, we will put it in writing and will abide by the agreement except when you require emergency treatment. If we do not agree to your request, we will notify you of our decision in writing.

By submitting this form, I hereby request that Washington Township Medical Foundation disclose of patient health information as described above. I understand and acknowledge that the clinic is not required to agree to this request.

Print name of Patient or Representative: ____

Signature of Patient or Representative: ____

FOR MEDICAL STAFF USE ONLY
Date form received: _______________________ **Staff initials:** ______________________

❑ I am withdrawing my permission to disclose my health information to the following family members, friends or other people involved in my care:

a. ______________________________ b. ___________________________

c. ______________________________ d. ___________________________

e. ______________________________

Print name of Patient or Representative: ________________________ Date: ________________

Signature of Patient or Representative: ____

FOR MEDICAL STAFF USE ONLY
Date form received: ________________ **Staff initials:** ________________