

## HIPAA Acknowledgement and Consent Form

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I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

\*Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.

\*Obtain payment from designated third-party payers.

\*Conduct normal health care operations such as quality assessments or evaluations, and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information (available in office in print form or on the office website <http://www.drwestwick.com>). I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address(s) below to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

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Patient's Name

Date of Birth (MM/DD/YYYY)

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Signed (Patient or Legal Representative for Patient)

Date

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Legal Representative's Relationship to Patient

Dr. Dwight Bostwick, O.D.  
125 Cottage Ave. \* (509) 782-1350  
Cashmere, WA 98815  
14 S. Wenatchee Ave. \* (509) 662-2653  
Wenatchee, WA 98801