BUCKNER®
Hope shines here®

CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

Name of Client/Individual: _____ Date of Birth: _____

I understand that BCFS will maintain, use and disclose personal health information in order to provide for my care and treatment, to arrange for billing and payment for care, and to carry out general management and operations of BCFS such as quality review.

I understand that these and other uses and disclosures of my personal health information are described more completely in the facility's Notice of Privacy Practices.

I understand that I have the following rights:

- The right to receive and review the BCFS Notice of Privacy Practices before signing this Consent.
- The right to request restrictions on how protected health information about me is used or disclosed for treatment, payment or health care operations. BCFS is not required to agree to my request, but if it does, it will be bound by its agreement.
- The right to revoke this Consent, in writing, except to the extent that BCFS has acted in reliance on the Consent.
- The right to receive a copy of this Consent form.

I consent to the use and disclosure by Buckner Children and Family Services, Inc. and its agents or representatives of all my personal health information for purposes of treatment, payment and health care operations. I agree that a copy of this document will also serve as an original.

By signing below, I acknowledge that I have read and understand this Consent form.

_____ _____
Signature of Client Date

_____ _____
Signature of Parent/Managing Conservator (if applicable) Date

If signed by the client's Representative, please print name and describe relationship to client:

_____ _____
Name Relationship to Client

EFFECTIVE DATE:_____

THE EXPIRATION DATE OF THIS CONSENT IS CONSIDERED TO BE THE DATE BUCKNER RECEIVES REVOCATION IN WRITING.

FACILITY USE ONLY **Restriction Requests**

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