Children with Special Health Care Needs (CSHCN) Program

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT TO USE AND DISCLOSE FOR TREATMENT, PAYMENT AND HEALTH OPERATIONS PURPOSES

PATIENT

Name: _____

Date of Birth: _____ ID Number:_____

I hereby consent for the Children with Special Health Care Needs (CSHCN) Program to use and disclose my protected health information for treatment, payment and health care operations purposes. These purposes are described, and examples of each purpose are given, in CSHCN's attached Notice of Privacy Rights. This also acknowledges that I have received a copy of the CHSCN Notice of Privacy Rights. I retain the right to request restrictions on how and to whom the protected health information may be released, although CSHCN does not have to accept my restrictions.

A person or organization that receives my information because of this consent may have the legal right to disclose this information to other people or organizations without my knowledge or consent.

Signature: _____ Date: _____

Witness: _____ Witness: _____

If this authorization is signed by someone who is not the patient listed at the top of this form, provide a description of the signer's authority to act for the patient.

Type of authority: _____

Documentation Provided_____ yes _____ no

Disposition: To be filed in the patient's medical record. May also be filed with the Privacy Official.