MEMBER PLUS FAMILY HEALTH
Personalized Health Care for Bainbridge Island

Gregory E. Keyes, M.D.
American Board of Family Practice

Blain Crandell, M.D.
American Board of Family Practice

123 Bjune Drive SE, Suite 101
Bainbridge Island, Washington 98110
www.memberplusfamilyhealth.com
Tel: 206.842.3222
Fax: 206.842.1877

CONSENT TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION

Dr. Keyes and Dr. Crandell provide this form to comply with The Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Federal Government requires all medical offices to make patients aware of their rights regarding the use of their protected health information (PHI). As a patient of Member Plus Family Health you have the right to know how we use and disclose your PHI. Detailed information about this is covered in our **Notice of Privacy Practices**, which has been offered to you. A copy of this document can also be found on our website. A full description of the law can be found on the website: www.hhs.gov/OCR/privacy/HIPAA.

This form contains a summary of your rights as a patient as it pertains to your protected health information. Our office is committed to your right to privacy and confidentiality and all staff has received training in the laws of HIPAA. You have the legal right to review our Notice of Privacy Practices before signing this form. You should read this notice carefully before signing this form.

- This medical practice collects health information about you and stores it in a chart and in an electronic medical record (EMR). The law permits us to use or disclose your health information for the purposes of treatment, to obtain payment for services provided and for health care operations. Each of these areas is addressed in our Notice of Privacy Practices.
- You have the legal right to request in writing that we not disclose information about you for some kinds of treatment, payment or health care operations
- You have the right to request to inspect and/or obtain a copy of your PHI.
- You have the right to request that we amend your PHI, with certain restrictions as outlined in the Notice of Privacy Practices.
- You have the right to complain about alleged privacy violations by our practice.
- You have the right to revoke this consent at any time and must do so in writing. This will not apply to the use or disclosure of any information that has already been released.
- We may change our Notice of Privacy Practices from time to time. If we make any changes, we will make a copy of the amended notice available to you at your next appointment, as well as posting an update on our website.
- By signing this form you agree to the above conditions and acknowledge that you have been offered a copy of our Notice of Privacy Practices.
- You have the right to request restrictions on certain uses and disclosures of your health information and we ask that you give us written consent to share your health information with certain individuals such as family members or friends. We will not share information with family or other individuals unless you have given us this written consent.

I authorize Dr. Keyes & Dr. Crandell and his staff to share information related to my health care with the following individuals:

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

Please indicate below if there is any exclusion to shared information:
_____ Information related to psychiatric or behavioral issues
_____ Information related to substance abuse
_____ Other exclusions or specific restrictions that you request. Please provide details of the restrictions you are requesting:

_____

Authorized Signature_____**Date**_____

Please Print Name_____