**HIPAA Acknowledgment and Consent**

I understand that Your Care, LLC will use and disclose health information about me.

I understand that my health information may include information both created and received by Your Care, LLC may be in the form of written or electronic records or spoken words and may include information about my health history, health status, symptoms, examinations, test results diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that Your Care, LLC may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment;
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- Perform various office, administrative and business functions that support my provider's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how Your Care, LLC will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other personnel of Your Care, LLC, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy of the most current version of Your Care's Notice of Privacy Practices in effect will be available in the waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that Your Care, LLC is not required by law to agree to such requests.

**By signing below, I agree that I have reviewed and understand the information above and that I have either received or declined to receive a copy of the Notice of Privacy Practices.**

**Please Print:** **Last Name:**_____ **First Name:**_____

_____ _____

DATE SIGNATURE OF PATIENT OR PERSON AUTHORIZED BY LAW AND RELATIONSHIP

**Please list below anyone to whom we can release your (or your child's) protected health information without specific authorization**

_____ _____

Name Relationship

_____ _____

Name Relationship