St. Joseph-Buchanan County Health Department
904 S. 10th, St. Joseph, MO 64503
Phone: 816-271-4636; Fax 816-271-4764

Client Name ______________________________
Print *Client's First Name, Middle Initial and Last Name*

Date of Birth __________ __________ __________
Month *Day* *Year*

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

I give permission to the St. Joseph-Buchanan County Health Department to share health information about the above named client with participating care providers when appropriate in order to provide the above named client treatment or health related services.

I understand that the confidentiality of the information will be maintained as required by applicable state and federal laws. I have been provided with information about the St. Joseph-Buchanan County Health Department privacy and confidentiality policies and have been told where I can obtain a current copy of that information. I have read the Notice or I have had an opportunity to read it. I further understand information will not be given to care providers that do not have the proper authorization or have not signed an agreement with the Health Department or be used for any other purpose except in an aggregate form, without my specific written permission. I have been advised that I have the right to review my health care information and to have the information updated if inaccurate. Finally, I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the organization is not required to agree to the restrictions requested.

I understand that the Health Department reserves the right to change the Notice of Privacy practices and that I have a right to see the revised Notices.

This consent remains in effect unless I give written notice to revoke. I understand my refusal to give permission will not influence the services I receive.

____
Print Client/Parent/Guardian First Name, Middle Initial and Last Name

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Client/Parent/Guardian Signature Date

____
Witness Signature Date

St. Joseph-Buchanan County Health Dept. (816) 271-4636
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Title of Witness (***Print***) Agency Name & Telephone Number