HIPAA Acknowledgment /Consent

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- The day-to-day healthcare operations of your practice
- The Use of Electronic medical record that are passcode protected on a mobile device

I have also been informed of and given the right to review and secure a copy of the Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with these restrictions.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

If you have record available from prior birthing at the Birthing Center, Blessed Beginnings Care Center or New Eden Care Center, consent is implied to obtain those record if needed.

I provide permission in case of an transfer or additional provider consults to share my HIV status and Psych history. Additionally, I require all of my patient to get HIV/RPR and Rubella tested. Your signature give me permission to obtain those tests.

I understand that I am responsible to pay for the services provided to me at the time of service.

At this time I consent for consultation and treatment by Jana Schenkel CNM. I do understand that an informed consent will be signed for specific procedures or if any additional special needs to be given.

________________________________ Date_________________________________

Patient

________________________________ Date_________________________________

Witness