ASHTABULA COUNTY BOARD OF DEVELOPMENTAL DISABILITIES

HIPAA CONSENT FORM

I hereby give my consent for the Ashtabula County Board of Developmental Disabilities (ACBDD) to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

The Notice of Privacy Practices provided by the ACBDD describes such uses and disclosures more completely.

I acknowledge the receipt of ACBDD's Notice of Privacy Practices. I have the right to review the Notice of Privacy Practices prior to signing this consent. ACBDD reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

Jill Oliver, HIPAA Privacy Officer
5959 Green Road
Ashtabula, OH 44004
or by email: Jill.Oliver@ashtabuladd.org

With this consent, ACBDD may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the organization in carrying out TPO, such as appointment reminders, meeting information, reports, etc.

With this consent, ACBDD may mail to my home or other alternative location any items that assist the organization in carrying out TPO, such as appointment reminders, meeting information, reports, etc. as long as they are marked "Personal and Confidential".

With this consent, ACBDD may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders, meeting information, reports, etc.

I have the right to request that ACBDD restrict how it uses or discloses my PHI to carry out TPO. The organization is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

Restrictions:_____
_____
_____

I may revoke my consent by forwarding a written request to: Jill Oliver, HIPAA Privacy Officer, 5959 Green Road, Ashtabula, OH 44004, or by email: Jill.Oliver@ashtabuladd.org except to the extent that the organization has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, ACBDD may decline to provide services to me.

By signing this form, I am acknowledging receipt of ACBDD's Notice of Privacy Practices and consenting to allow ACBDD to use and disclose my PHI to carry out TPO.

_____ _____
Signature of Individual or Representative Date

_____ _____
Printed Name of Individual or Representative Relationship to Individual