West Omaha Family Physicians, P.C.
17030 Lakeside Hills Plz, Suite 130, Omaha, NE 68130 ● Phone: (402) 758-5150 ● Fax: (402) 758-5158

HIPAA CONSENT

Consent to use and disclose protected health information for treatment, payment, and healthcare operations

As a patient you can:

- Inspect and copy your information
- Request corrections to your information
- Request that your information be restricted
- Request confidential communication
- Obtain a report of disclosures of your information
- Obtain a paper copy of this notice

I understand that I may revoke my consent in writing, except to the extent that the organization has already taken action in reliance thereon. I understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that West Omaha Family Physicians, P.C. reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should West Omaha Family Physicians, P.C. change their notice, they will send a copy of any revised notice to the address I've provided.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I authorize West Omaha Family Physicians, P.C. to release personal health information to the following people:

_____ _____

Name Relationship Name Relationship

I fully understand and accept the terms of these Privacy Consents

_____ _____

Signature of patient or legal guardian Date of birth

_____ _____

Patient's name (printed) Today's date