



ACKNOWLEDGMENT AND CONSENT FOR TREATMENT

I am voluntarily applying for services at the Deschutes County Health Services (DCHS). I understand and agree that Deschutes County Health Services (DCHS) 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, including other providers within DCHS, 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;
- Perform various office, administrative, and business functions that support DCHS efforts to provide me with, and be reimbursed for, quality cost-effective health care; and
- Participate in the following as described in the Notice of Privacy Practices for Deschutes County Health Services;
  - Communicate with me through MyChart, an online secure patient portal.
  - As a member of the Reliance Community Health Information Exchange
  - Deschutes County Health Services is a member of an electronic health information exchange (HIE) called the OCHIN Collaborative. A purpose of this HIE is to allow health care providers to electronically share records regarding an individual. I understand and agree that DCHS may disclose any of my health information, including drug and alcohol treatment information protected by 42 CFR Part 2, to this HIE for the purpose of sharing the information with any individual or entity that has a treating provider relationship with me at the time he/she/it accesses the information. I understand that upon my written request, the HIE must provide me with a list of all entities to which my information has been disclosed within the past two years. The HIE would be responsible for responding to the request within 30 days.

I understand that my health information may include information both created and received by DCHS, 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 that the health information used or disclosed may include vocational rehabilitation, alcohol and drug records, HIV/AIDS records, genetics information, and mental health or developmental disability records held by publicly funded providers. I understand that I may be offered telehealth/phone options for services, and if so, my provider will talk to me about whether this is appropriate for my services.

I understand that the Notice of Privacy Practices for Deschutes County Health Services may be revised from time to time and that I am entitled to receive a copy of any revised version. I also understand that a copy or a summary of the most current version of the Notice of Privacy Practices for Deschutes County Health Services in effect will be posted in the waiting / reception areas.

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 for Deschutes County Health Services, and I understand that DCHS is not required by law to agree to such requests.

**By signing below, I agree that I am requesting services from DCHS, have reviewed the information above and that I have been offered a copy of the Notice of Privacy Practices for Deschutes County Health Services.**

Print Client's Name: \_\_\_\_\_ Client's Date of Birth: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Client, guardian or authorized personal representative*

Print Name if signed by someone other than client: \_\_\_\_\_