

# CHRISTIAN CARE CENTERS, INC.

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

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Name of Resident: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I consent to the use and disclosure by Christian Care Centers, Inc. and its agents or representatives of all my personal health information for purposes of treatment, payment and health care operations.

- ✍ I understand that the facility maintain, use and disclose personal health information in order to provide for my care and treatment, to arrange for billing and payment for my care and carry out general management and operations of the facility such as quality review.
- ✍ I understand that these and other uses and disclosures of my personal health information are described more completely in the facility's Notice of Privacy Practices.
- ✍ I understand that the facility reserves the right to change its privacy practices described in the Notice of Privacy Practices and to make the new Notice provisions effective for all protected health information already received and maintained by the facility as well as for new information. I understand that prior to implementation, the facility will mail a copy of the revised Notice of Privacy Practices to the address I have provided
- ✍ I understand that I have the following rights:

1. The right to receive and review the facility's Notice of Privacy Practices before signing this Consent.
2. The right to request restrictions on how protected health information about me is used or disclosed for treatment, payment or health care operations. The facility is not required to agree to my request, but if it does, it will be bound by its agreement.
3. The right to revoke this Consent, in writing at any time, by submitting a request to the Administrator, except to the extent the facility has acted in reliance on the Consent.
4. The right to receive a copy of this Consent form.

By signing below, I acknowledge that I have read and understand this Consent form.

\_\_\_\_\_  
Signature of Resident or Resident's Authorized Representative

\_\_\_\_\_  
Date

If signed by the Resident's Representative, please print name and describe relationship to resident.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship to Resident