

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

Name of Client/Individual: ______Date of Birth: _____

THE EXPIRATION DATE OF THIS CO	CONSENT IS CONSIDERED TO BE THE DATE BUCKNER RECEIVES REVOCATION IN WRITING. Restriction Requests
EFFECTIVE DATE:	
Name	Relationship to Client
If signed by the client's Representative, pl	please print name and describe relationship to client:
Signature of Parent/Managing Conservator	tor (if applicable) Date
Signature of Client	Date
of all my personal health information for percopy of this document will also serve as a	uckner Children and Family Services, Inc. and its agents or representative ourposes of treatment, payment and health care operations. I agree that an original. ave read and understand this Consent form.
The right to receive a copy of this	s Consent form.
 The right to revoke this Consent, i Consent. 	in writing, except to the extent that BCFS has acted in reliance on the
	on how protected health information about me is used or disclosed for re operations. BCFS is not required to agree to my request, but if it does,
The right to receive and review the	he BCFS Notice of Privacy Practices before signing this Consent.
I understand that I have the following right	nts:
completely in the facility's Notice of Privac	nd disclosures of my personal health information are described more cy Practices.
I understand that these and other uses an	
and treatment, to arrange for billing and pa BCFS such as quality review.	e and disclose personal health information in order to provide for my care payment for care, and to carry out general management and operations of

HIPAA Consent 3/1/2011