564 E. Woolbright Road
Boynton Beach, FL 33435

Phone: (561) 735-6533
Fax: (561) 735-7739

Acknowledgement and Consent

Patient Name: _____

I understand that my health information may include information both created and received by Genesis Community Health, may be in 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 and agree that Genesis Community Health 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 for my care and treatment;
- Determine my eligibility for my 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 and
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange, and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how Genesis Community Health will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health related information made and the information practices followed by the employees, staff, and other office personnel of Genesis Community Health and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or summary of the most current version of Genesis Community Health's Notice of Privacy Practices in effect will be posted in waiting/reception area and are available on the website at www.gencomhealth.org

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, and I understand that Genesis Community Health is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

_____ _____

Patient Signature Date

_____ _____

Patient Representative Date