



Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy at our web site, www.lake-health.com. Or by making a request in writing to Sheila Gage, Health Information Management Services, Lake District Hospital, 700 South J. Street, Lakeview, OR 97630.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Name of Patient

Signature of Patient or Representative

Date signed

Name of Representative (if applicable)

Relationship to Patient

Description of Representative's Authority: