Cottonwood Creek Clinic LLC
3600 E Wickersham Way
Wasilla, AK 99654
Phone 907-373-5950
Fax 907-373-5954

HIPAA Acknowledgement and Consent Form

The Privacy Act was created in order to provide a standard for health care providers to obtain their patient's consent for uses and disclosure of health information about the patient to carry out treatment, payment or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take responsible precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information about treatment. Payment or health care operations, in order to provide services that are in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect relationships with you (i.e. laboratories that only interact with physicians) and may have to disclose personal health information for the purpose of treatment, payment, or health care operations. Their entities are not required to obtain patient consent.

I understand that my health information may include information both created and received by the practice, may be in the form of writing, electronic records, 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 this practice 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 health plans or insurance coverage, and submit bills, claims and other related information to insurance companies or a responsible agent for payment of my health care.

Perform various office, administrative, and business functions that support my physician's effort to provide me with, arrange and be reimbursed for quality health care.

You may refuse to consent to the use or disclosure of your personal health information but this must be in writing as mandated by the Privacy Act. Under this law, we have the right to refuse treatment should you choose not to disclose your information. I also understand that I have the right to ask that some or all of my health care information not be used or disclosed, and understand that this practice is not required by law to agree with such request.

I have reviewed and understand this consent form:

Patient Signature:_____ DOB_____
Printed Name: _____ DATE_____

People Authorized to get medical / billing information.

Name: _____ Phone _____
Relationship: _____

Name: _____Phone _____
Relationship: _____

Name: _____ Phone _____
Relationship: _____

Name: _____ Phone _____
Relationship: _____

Name: _____ Phone _____
Relationship: _____

Name: _____ Phone _____
Relationship: _____

Name: _____ Phone _____
Relationship: _____

Patient Signature:_____ Date:_____
Printed Name:_____