Cascade ID & Infusion

Receipt Acknowledgment of CIDI's Notice of Privacy Practices

Last Name:_____First Name:_____Date of Birth: ____/____/____

I understand that Cascade ID and Infusion, LLC will use and disclose health information about me. I understand that my health information may include information both created and received by the practice. It may be in the 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 and prescriptions and similar types of health-related information.

I understand that I have the right to receive and review a written description of how Cascade ID and Infusion, LLC 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 information made and the information practices followed by employees, physicians and other personnel of Cascade ID and Infusion, LLC 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 of the most current version of Cascade ID and Infusion, LLC Notice of Privacy Practices is available in the lobby and on our website at www.cascadeinfusion.com.

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 Cascade ID and Infusion, LLC is not required by law to agree to such requests.

I understand Cascade ID and Infusion, LLC is restricted in discussing my health information with family members and friends without written permission. I hereby authorize Cascade ID and Infusion, LLC to release medical information regarding myself to the person(s) listed below. I understand this information may include diagnosis treatment and lab or x-ray results.

Consent to Release Information: PERSON(S) AUTHORIZED TO RECEIVE INFORMATION:

Name	Relationship to You

(Please Print)

_____ _____

Patient's Signature *Date*

_____ _____

Legal or Personal Representative of Patient (if applicable) *Relationship*

Attach photo ID with signature of patient or legal representative if not verified with staff at time of signing.

I agree that I have reviewed and understand the information above and that I am free to take a copy of the Notice of Privacy Practices available at the reception counter and online at www.cascadeinfusion.com.

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