

CLIENT CONSENT FOR PROGRAMS MANAGED BY ARCADIA ELDER SERVICES TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

I, _____, (CLIENT) hereby consent to the use or disclosure of my individually identifiable health information (Protected Health Information) by Arcadia Elder Services (AES) in order to carry out treatment, payment, or health care operations. CLIENT has access to AES' Notice of Privacy Practices for Protected Health Information (Notice) for a more complete description of the potential uses and disclosures of such information, and the right to review such Notice prior to signing this consent form.

AES reserves the right to change the terms of its Notice at any time. If AES does change the terms of its Notice, CLIENT may obtain a copy of the revised Notice from the Program Director of programs managed by AES.

CLIENT retains the right to request that AES further restrict how CLIENT's Protected Health Information is used or disclosed to carry out treatment, payment, or health care operations. AES is not required to agree to such requested restrictions; however, if AES does agree to CLIENT's requested restriction(s), such restrictions are then binding on AES.

At all times, CLIENT retains the right to revoke this Consent. Such revocation must be submitted to AES in writing. The revocation shall be effective on the date received *except* to the extent that AES has already taken action in reliance on the Consent.

AES may refuse to treat CLIENT or to permit CLIENT to enter or to continue to remain in programs managed by AES if CLIENT (or an authorized representative) does not sign this Consent Form. If CLIENT (or authorized representative) signs this Consent Form and then revokes that Consent, AES has the right to refuse to provide further treatment to the CLIENT and to refuse to permit CLIENT to enter or to continue to remain in programs managed by AES as of the time of revocation.

I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE PARTICPANT, OR AM AUTHORIZED TO ACT ON BEHALF OF THE PARTICPANT TO SIGN THIS DOCUMENT, VERIFYING MY CONSENT TO THE ABOVE-STATED TERMS.

Date: _____ Time _____ AM/PM

Signature of CLIENT

Print

Person signing on behalf of CLIENT*

Print

* Please explain Representative's Relationship to CLIENT and include a description of Representative's Authority to act on behalf of the CLIENT:

