



NEHALEM BAY
HEALTH CENTER & PHARMACY
COMPASSIONATE COMMUNITY CARE

Received By: _____
Entered By: _____

885 Nehalem Blvd | PO Box 176 | Wheeler, OR 97147 | 1-800-368-5182 | Fax: 1-844-712-3001 | Nehalembayhealth.org

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

I understand that Nehalem Bay Health Center (referred to below as “NBHC”) will use and disclose health information about me.

I understand that my health information may include information both created and received by NBHC and 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, prescriptions and similar types of health-related information.

I understand and agree that NBHC 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 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 provider’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 NBHC will handle health information about me. This written description is known as the Health Insurance Portability and Accountability Act (HIPAA) and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of NBHC, and my rights regarding my health information.

I also understand that a copy of the Health Insurance Portability and Accountability Act (HIPAA) is posted in the waiting/reception area of NBHC.

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 Health Insurance Portability and Accountability Act (HIPAA), and I understand that NBHC is not required by law to agree to such requests.

By signing below, I agree that I have reviewed, and I understand, the above information. I may request a copy of the Health Insurance Portability and Accountability Act (HIPAA).

By: _____ Date: _____
(Patient/Guardian/Patient Representative)