

ARE YOU READY FOR HIPAA?
(The Health Insurance Portability and Accountability Act)

**Consent For the Use and Disclosure of
Protected Health Information**

I hereby consent to the use and disclosure of my Protected Health Information by my Benefits Coordinator in order to carryout Treatment or Payment. I understand that Protected Health Information means my health information, which is individually identifiable by name, social security number or date of birth.

I understand that uses and disclosures for Treatment and Payment include but are not limited to:

- Submit health information to the health insurance company in order to obtain payment for treatment or services rendered.
- Share health information with other health care providers in which I have a treatment relationship.
 1. Treatment: As a health plan, the Plans do not provide treatment services.
 2. Payment: The Plans may use and /or disclose your PHI in order to process payment, including receiving bills, or determining eligibility or coverage for the treatment and services provided to you.

I understand that the terms of the HIPAA Notice of Privacy Practices may change and that I may request a revised notice by contacting the person listed above.

I understand that I have the right to request the Benefits Coordinator restrict how it uses and discloses my Protected Health Information in order to carry out Treatment and Payment. I understand that the Benefits Coordinator is not required to agree to the restrictions, but that if he or she agrees, the restriction is binding.

I understand that I have a right to revoke this consent, but that I must do so in writing.

Signed: _____ Date: _____

Name(Print): _____

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