Dear Patient,

The Health Insurance Portability and Accountability Act (HIPAA) requires us to provide you with notice of our privacy practices.

Please provide written acknowledgment that you have received and reviewed the attached Notice of Privacy Practices and Notice of Health Information Practices. These notices explain how our office may use protected health information about you, or disclose it, for treatment, payment, or healthcare purposes.

You may request that we restrict how we use or disclose your health information to carry out treatment, payment or healthcare operations. We are not required to agree to the requested restrictions; however, if we do agree to a requested restriction, we are bound by that restriction.

The privacy notice is subject to change because we continuously seek new ways to protect your health information. If we change this privacy notice, you may obtain a revised copy at the front desk or by writing to our Privacy Officer at Mariposa Community Health Center, 825 N. Grand Avenue, Suite 100, Nogales, AZ 85621.

Please provide written consent for treatment below. This consent will allow a Mariposa to see and treat your child from the school either in person or via telemedicine even if you are not present. You also authorize the school nurse or other representative to click the button on your behalf to start a telemedicine virtual visit expressing that they are the legal representative that agree to the terms of use, privacy policy, and the use of telemedicine. This will enable us to process payments and proceed with our healthcare operations. You have the right to revoke this consent in writing, except where we have already processed or used the information for treatment, payment, and healthcare operations.

Also attached are your rights as a patient. Please acknowledge that you have received them below. In the event that there are any changes to patient rights, note that these will be posted in the lobbies of all Mariposa buildings and available upon request at the front desk.

Our goal is to protect your privacy and your rights. Your signature below indicates that you have received and reviewed the notices described above and consent to treatment.

Sincerely,
Mariposa Administration

_____

Patient Signature Date

_____

Please print name here