



Notice of: Privacy Practices, Health Information Practices, & Patient Rights | Consent to Treat

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 ensure the protection of your health information. If we change this privacy notice, you may obtain a revised copy by requesting one 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. If you are a parent or guardian filling this out for someone, this consent will allow a Mariposa provider to see and treat you or your child from a Mariposa location or a 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 agrees to the terms of use, privacy policy, and the use of telemedicine on your behalf. If you are filling this form out for yourself, this provides your consent for us to treat you. Either way, 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. Your signature below is an acknowledgment that you have received and reviewed the notices described above and consent to treatment.

Sincerely,
Mariposa Administration

Patient Signature

Date

Please print name here