

WASHINGTON COUNTY MENTAL HEALTH DISABILITY SERVICES

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT

I acknowledge that I have received a copy of the Notice of Privacy Practices from Washington County Mental Health Disability Services (WCMHDS). I have had the opportunity to review the document and understand that WCMHDS may disclose information about me without further consent, as required or permitted by law.

I also understand that my rights include the right to:

1. Receive a copy of my file
2. Request an amendment to my file
3. Request alternative communication methods
4. Request limited distribution of information in my file
5. Obtain an accounting of disclosures

By signing this acknowledgement and consent of the Washington County Mental Health Disability Services Notice of Privacy Practices, I am consenting to the use and disclosure of my personal health information at the “minimum necessary standard” for routine treatment, billing, and business operations.

Additionally, I acknowledge that if I have a complaint or concern regarding my privacy, I may communicate those concerns to either the Washington County Mental Health Disability Services Privacy Officer or the MHDS Director.

Signature of Individual/Legal Representative

Date