Acknowledgement of Receipt of Notice of Privacy Practices and Consent Form Dayspring Village, Inc.

I acknowledge the receipt of the Notice of Privacy Practices of Dayspring Village, Inc.

I consent to the use and disclose of Protected Health Information about me for treatment, payment, and health care operations and other permitted uses and disclosures as described in the Notice of Privacy Practices.

This means that information about my health will be used by the staff of Dayspring Village, Inc. or disclosed to other people or organizations whenever needed to:

- Provide treatment to me or arrange for treatment by another health care provider;
- Arrange for payment for services to me;
- Operate the business of Dayspring Village, Inc.; and
- Enable other health care organizations to provide treatment to me or pay for services for me to review the quality and appropriateness of care I receive and conduct other health care operations.

I understand that information disclosed pursuant to this consent may be re-disclosed by the recipient of the information. Most health care providers and all health benefit plans are obligated to follow federal rules and state laws for protection of the privacy or your health information.

I understand that there is no time limit on this consent. I also understand that I may revoke this consent at any time.

I am the person who is the subject of the health records that will be used or disclosed.

_____ _____

Signature Date

I am the personal representative of the resident who is the subject of the health records maintained by Dayspring Village, Inc. My relationship to that person is _____

_____ _____

Signature of Personal Representative Date