AMERICAN SAMOA MEDICAID STATE AGENCY
OFFICE OF THE GOVERNOR
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AMERICAN SAMOA 96799
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Medicaid OMRNZ Patient Consent Form

Please read below before signing.

The Health Insurance Portability and Accountability Act (HIPAA) Public Law 104-191 established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As a patient of the OMRNZ Program, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. When it is appropriate or necessary, we provide the minimum necessary information only to those we feel are in the need of your health care information regarding treatment, payment, or health care operations, in order to provide health care that is in your best interest.

You may refuse to consent to the use or disclosure of your personal health information but this must be done, in writing, signed by you. Under this law, the Medicaid Office has the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information. You may not revoke actions that have already been taken which relied on this or a previous signed agreement.

The Medicaid Office and its NZ medical providers will collect, use and disclose information about you for the following purposes:

- To deliver safe and efficient patient care
- To identify and to ensure continuous high-quality service
- To assess your health needs and suitability for travel to, and treatment, in New Zealand
- To provide access to healthcare to New Zealand
- To advice you of available treatment options
- To establish and maintain communication with you
- To provide you with an accurate quote for your travel and treatment package
- To communicate with other treatment options
- To book and confirm appointments with specialists and other healthcare providers
- For teaching and demonstrating purposes on an anonymous basis
- To process credit payments

By signing this consent section of this Patient Consent Form, you agree that you have given your informed consent to the collection, use and/or disclosure of your personal and medical information for the purposes that are listed. If a new purpose arises for the use and/or disclosure or personal information, we will seek your approval in advance.

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The patient has the right to restrict the uses of their information but Medicaid does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- Medicaid and its NZ medical providers may condition receipt of treatment upon execution of this consent.

This consent was signed by:

_____
Printed Name-Patient or Legal Guardian **Date**

_____
Relationship to Patient (if other than the patient)

_____
Signature **Date**

Witness:

_____
Printed Name of Medicaid Representative

_____
Signature **Date**

IMPORTANT MESSAGE: The consent form is only valid for the duration of your medical referral under the American Samoa Medicaid OMRNZ Program. You may revoke the appointment at any time in writing and may submit it to us either in email at omr@medicaid.as.gov or at our office located in Tafuna.