THE WOMEN & CHILDREN'S NATURAL HEALTH CENTER

PATIENT CONSENT
FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION
TO CARRY OUT TREATMENT AND HEALTH CARE OPERATIONS

I hereby state that by signing this consent, I acknowledge and agree as follows:

1. The Privacy Notice includes a complete description of the uses and/or disclosure of my protected health information (PHI) necessary for the Practice to provide treatment and to carry out its health care operations. The Women and Children's Natural Health Center (hereafter referred to as the Practice) Privacy Notice has been provided to me for the review prior to signing this consent. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this consent, and has encouraged me to read the Privacy Notice carefully prior to signing this consent.

2. In accordance with applicable law, the Practice reserves the right to change its privacy practices that are described in its Privacy Notice.

3. I understand and consent to the following appointment reminders that may be used by the Practice a) telephoning my home and leaving a message on my answering machine or with the individual answering the phone and/or b) mailing a postcard to me at the address provided by me.

4. In order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations, the Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me).

5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or healthcare operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

6. I understand that this Consent is valid for seven (7) years. I further understand that I have the right to revoke this Consent in writing at any time for all *future* transactions, with the understanding that such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

8. I understand that if I do not sigh this Consent, evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice and all of my questions have been answered to my full satisfaction in a way that I can understand.

______________________________	______________________________
Name of Individual (Printed)	Signature of Individual
______________________________	______________________________
Signature of Legal Representative	Relationship

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Date Signed

Please turn page over to continue.

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HIPAA/ PATIENT RECORD OF DISCLOSURE

In general, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (*Please check all that apply*)

______ Home Telephone ( ) ____________________
- ☐ OK to leave messages with detailed information
- ☐ Leave message with call-back number only

______ Work Telephone ( ) ____________________
- ☐ OK to leave messages with detailed information
- ☐ Leave message with call-back number only

______ Cell/ Mobile Telephone ( ) ____________________
- ☐ OK to leave messages with detailed information
- ☐ Leave message with call-back number only

______ Written Communication
- ☐ OK to mail to my home address:

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- ☐ OK to mail to my work/ office address:

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______________________	______________________	__________
Patient's Signature	Print Name	Date