CONSENT FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATION

I consent to the use or disclosure of my identifiable health information by Park Acupuncture and Herbal Medicine Clinic (hereafter organization) for the purposes of diagnosis or providing treatment to, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me at this organization may be conditioned upon my consent as evidenced by my signature on this document.

I understand and have been provided with a Notice of Privacy Practices that provides a more completed description of information uses and disclosures. I have read the Notice of Privacy practices, have had the opportunity to ask questions regarding its content and meaning and fully understand its content and implication.

I understand I have the right to review the notice prior to signing this consent.

I understand I have the right to request a restriction as to how my identifiable health information is used or disclosed to carry out treatment, payment or health care operations and that the organization is not required to agree to the restrictions that I may request.

I understand that I may revoke this consent, in writing, at any time except to the extent that the organization has taken action in reliance on this consent.

My identifiable health information means health information, including my demographic information, collected from me and created or received by my practitioner, another health care provider, a health plan, my employer or a health care clearinghouse. This identifiable health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand that the organization reserves the right to change information contained in the Notice of Privacy Practices and terms and will mail a copy of any revised notice to the address I've provided prior to implementation. I may obtain a revised Notice of Privacy Practices by accessing the website or requesting the most current notice during any office visit.

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Signature of Patient or Authorized Representative Date

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Printed Name and Relationship