Patient Consent Form for Use and Disclosure of Protected Health Information

By signing this Consent Form, you give us permission to use and disclose protected health information about you for treatment, payment, and health-care operations except for any restrictions specified below to which we have agreed. *Protected health information* is individually identifiable information we create or receive, including demographic information, relating to your physical or mental health, for provision of health care services to you, and to the collection of payment for providing health-care services to you.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to receive a copy of our Notice of Privacy Practices before signing this Consent Form. As provided in our Notice, the terms of the Notice of Privacy Practices may change. If we change our Notice, you may obtain a revised copy by contacting emailing anozofwellness@gmail.com or visit anozofwellness.com under the forms section.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health-care operations. ***We are not required to agree to any restrictions, but if we do, we are bound by our agreement.*** If you wish to make a restriction, please email us. If you do not sign this Consent form, we have the right to refuse you treatment unless a licensed health-care professional has determined that you require emergency treatment, or we are required by law to treat you. We are required to document any circumstances in which we do not obtain your consent yet carry out treatment. We will offer you a copy of this documentation should you decide not to sign this Consent Form. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. You may request to use our Authorization for Release of Information Form for purposes of requesting your revocation, or you may simply send us a letter in writing.

_____ _____

PRINT PATIENT NAME DATE OF BIRTH

_____ _____

PRINT PATIENT PERSONAL REPRESENTATIVE NAME

_____ _____

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE DATE OF SIGNATURE

*** PERMISSION REGARDING DISCLOSURE OF YOUR/YOUR CHILD'S HEALTHCARE INFORMATION ***
I hereby authorize An oz. of Wellness Healthcare Locations to speak to the individual(s) named below regarding my child's protected health information (optional):

NAME: _____ Relationship to Patient: _____

NAME: _____ Relationship to Patient: _____

Locations: http://anozofwellness.com/locations.html