Four Seasons Acupuncture, Inc.

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

My Notice of Privacy Practices provides information about how I may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review my Notice before signing this Consent. The terms of this notice may change. If I change this Notice, you may obtain a revised copy by contacting my office.

You have the right to request that I restrict how protected health information about you is used and disclosed for treatment, payment, or health care operations. I am not required to agree to this restriction, but if I do, I shall honor this agreement.

By signing this form, you consent to my use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures I have already made in reliance on your prior Consent. My practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but the Practice 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.
- The Practice may condition treatment upon the execution of this Consent.

Patient Signature or Legal Representative: _____

Relationship to Patient (if other than patient): _____

Date: _____

Witness Signature: _____

Date: _____