Consent for Use and Disclosure of Health Information

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

You have the right to read our Notice of Privacy Practices before your decide whether to sing this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised notice of Privacy Practices. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of your Notice of Privacy Practices at anytime. You will have the right to revoke this consent at anytime by giving us written notice of your revocation. Please understand that revocation of this consent will not affect any action that we took in reliance on this consent before we received your revocation, and we may decline to treat you or continue treating if you revoke this consent.

I authorize you to disclose health information to:

◯ No Person at this Time .

◯ Spouse: _____
NAME ADDRESS PHONE

◯ Family:_____
NAME ADDRESS PHONE

◯ Friend :_____
NAME ADDRESS PHONE

I,_____ have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected heath information to carry out treatment payment activities and healthcare operations.

_____ _____ _____
Signature Date

REVOCATION OF CONSENT

I revoke my consent for your use and disclosure of my protected health information, payment activities and healthcare operations.

I understand that revocation of my consent will not affect action that you took in reliance on my consent before you received this written notice of revocation. I also understand that you may decline to treat or continue to treat me after I have revoked my consent

_____ _____ _____
Signature Date

Acknowledgement of Receipt of Privacy Practices Policy

I, _____, have received a copy of this office's Privacy Practices Policy.

I would like to receive telephone communication or messages via: (Check all that Apply)

- ◯ **Home Phone: _____**
- ◯ **Work Phone: _____**
- ◯ **Cell Phone: _____ Text Message - Yes or No**
- ◯ **Email: _____**

Appointment reminders can be sent via Email or Text (please circle which are preferred)

_____ _____
Signature Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but he acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other:

_____ _____
Cynthia L Milligan L.Ac. #NC 646 Date