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Acupuncture & Homeopathy Clinic

Homeopathic Practitioner
Doctor of Oriental Medicine
Acupuncture Physician
License #: AP4119
Web: www.anhclinic.com

PATIENT CONSENT TO THE USE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS PER HIPPA REGULATIONS

Our Notice of Privacy Practices provides information about how we 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 out Notice before signing this Consent. The terms of our notice may change. You may obtain a revised copy by contacting our office.

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 this restriction, but if we do, we shall honor that agreement.

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

The patient understands that:

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

Restrictions:

- With whom may we discuss your protected health information: Example spouse, children, other relatives, friends or caregivers:
  Name: _____ Relationship: _____
  Name: _____ Relationship: _____
  Name: _____ Relationship: _____

- Message or appointment reminders:
  I agree that Acupuncture & Homeopathy Clinic may contact me: Yes or No
  And leave a message: Yes or No
  at the following phone numbers: _____

I fully understand and accept ☐
Or decline ☐
The information in this Consent.

Patient Signature _____ Print Name _____ Date _____

Relationship to Patient (if not patient): _____

Witness Signature _____ Print Name _____ Date _____