ADVANCED HEALING
ACUPUNCTURE - MASSAGE - NUTRITION

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Consent for Purpose of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by Advanced Healing for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct healthcare operations. I understand that diagnosis or treatment of me by Advanced Healing may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of this practice. Advanced Healing is not required to agree to the restriction that I may request. However, if Advanced Healing agrees to a restriction that I request, the restriction is binding on Advanced Healing.

I have the right to revoke this consent, in writing, at any time, except to the extent that Advanced HEaling has taken action in reliance on this consent.

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

I understand I have the right to review Advanced Healing's Notice of Privacy Practices prior to signing this document. The Notice of Privacy describes the types of uses and disclosures my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operation at Advanced Healing's office. The Notice of Privacy also describes my rights and Advanced Healing's duties with respect to my protected health information.

Advanced Healing reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice by calling the office and requesting a revised copy be sent in the mail or ask for one at my next appointment.

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Signature of Patient Date

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Printed Name of Patient