Consent for Use and Disclosure of Personal Health Information

I hereby consent to the use and disclosure of my personal health information (PHI) for the purposes of treatment, payment, and healthcare operations, in accordance with the Health Insurance Portability and Accountability Act (HIPAA). This consent allows **Acupuncture Herbal Essence & Wellness Center** to:

- Provide medical treatment and care
- Coordinate my care with other healthcare providers
- Submit claims for services to insurance companies or other third parties (if applicable)
- Obtain payment for services rendered
- Communicate with me regarding appointments and treatment plans
-

Disclosure to Family Members and Others

I authorize the following individual(s) to be informed about my treatment and health status:

1. Name: _____ Relationship: _____
2. Name: _____ Relationship: _____

☐ **I do not authorize anyone other than myself to be informed about my treatment and health status.**

Revocation of Consent

I understand that I have the right to revoke this consent at any time by submitting a written request to **Acupuncture Herbal Essence & Wellness Center**. I also understand that any revocation will not affect information already used or disclosed based on this consent.

Acknowledgment of Receipt of Privacy Practices

I acknowledge that I have received and reviewed the *Notice of Privacy Practices* and understand how my health information may be used and disclosed. I may request a copy at any time.

Client/Patient Name (Print): _____

Signature: _____ **Date:** _____

If signed by a Personal Representative:

Name: _____

Relationship to Patient: _____

Description of Authority: _____