HIPAA PATIENT CONSENT AGREEMENT FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

To carry out treatment, healthcare or	perations, and payment for	healthcare rendered	
I, (print name)	hereby state that by s	igning this Consent, I acknowledge and	
agree as follows:			
THEIR PROTECTED HEALTH INFORM patient named below, and Huntsville (MATION is made this date na Chiropractic and Nutrition Ce	FOR THE USE AND/OR DISCLOSURE of med below by and between the "Parties", thenter, LLC., d/b/a Millar Functional Medicoroviders, employees, associates, agents, a	the ine
2. I was offered an individual copy of the is on display in the Millar Functional Med of MILLAR explained to me that the HIF MILLAR staff has further encouraged med 3. The Privacy Notice includes a cominformation ("PHI") necessary for MILLA payment for that treatment and to carry of	dicine waiting room for me to re PAA Privacy Notice will be ava the to read the Privacy Notice can applete description of the uses aR to provide treatment to me, out its health care operations;	rthermore a copy of the HIPAA Privacy Not ead prior to my signing this Consent. The stallable to me in the future at my request. The start of the prior to my signing this Consent; and/or disclosures of my protected heat and also necessary for the MILLAR to obtuite that are described in its Privacy Notice.	taff Γhe alth tain
accordance with applicable law;		•	
treatment provided to me) in order for the for the MILLAR to conduct its health care 7. I understand that I have a right to req	ny PHI (which includes inforn MILLAR to treat me and obtain e operations; quest that MILLAR restrict how	nation about my health or condition and to n payment for that treatment, and as necess of my PHI is used and/or disclosed to carry	ary out
I have requested. If the MILLAR agrees does not agree to my restrictions of my another provider. MILLAR is under no obtained a understand that this Consent is valid that I have the right to revoke this Consent.	to a requested restriction, then PHI then Millar, at its choice, rebligation for that referred provided for seven years after the ent, in writing, at any time for	e date of my last visit. I further understa all future transactions, with the understand	illar e to and ling
consent; 9. I understand that if I revoke this conserefer me to another provider. MILLAR is 10. I understand that if I do not sign this	sent at any time, MILLAR has under no obligation for that re Consent evidencing my consel	R has already taken action in reliance on to the right to refuse to resign as my doctor a ferred provider to accept you as a patient; nt to the uses and disclosures described to not accept me as a patient and is immediat	and me
I have read and understand the above my full satisfaction. I sign freely below		of my questions have been answered to	
(Printed) Name of Patient	Signature of Patient	 Date Signed	
Printed Name of Legal Represent	 tative* Signature of I	_egal Representative Date Signed	
*Attorney-in-Fact, Guardian, Pare	_	_	
Witness	Witness Date	Revised 01.01.25	