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

To carry out treatment, healthcare operations, and payment for healthcare rendered

I, (print name) _____ hereby state that by signing this Consent, I acknowledge and agree as follows:

1. This Agreement, the "**HIPAA PATIENT CONSENT AGREEMENT FOR THE USE AND/OR DISCLOSURE OF THEIR PROTECTED HEALTH INFORMATION** is made this date named below by and between the "Parties", the patient named below, and Huntsville Chiropractic and Nutrition Center, LLC., d/b/a Millar Functional Medicine hereafter called "MILLAR" including but not limited to its Doctors, Providers, employees, associates, agents, and assigns;
2. I was offered an individual copy of the HIPAA Privacy Notice and furthermore a copy of the HIPAA Privacy Notice is on display in the Millar Functional Medicine waiting room for me to read prior to my signing this Consent. The staff of MILLAR explained to me that the HIPAA Privacy Notice will be available to me in the future at my request. The MILLAR staff has further encouraged me to read the Privacy Notice carefully prior to my signing this Consent;
3. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for MILLAR to provide treatment to me, and also necessary for the MILLAR to obtain payment for that treatment and to carry out its health care operations;
4. MILLAR reserves the right to change its privacy policies and procedures that are described in its Privacy Notice, in accordance with applicable law;
5. I understand and freely consent to all of MILLAR's Privacy Notice disclosures;
6. MILLAR may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the MILLAR to treat me and obtain payment for that treatment, and as necessary for the MILLAR to conduct its health care operations;
7. I understand that I have a right to request that MILLAR restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, MILLAR is not required to agree to any restrictions that I have requested. If the MILLAR agrees to a requested restriction, then the restriction is binding on MILLAR. If Millar does not agree to my restrictions of my PHI then Millar, at its choice, may resign from my treatment and refer me to another provider. MILLAR is under no obligation for that referred provider to accept you as a patient;
8. I understand that this Consent is valid for *seven years after the date of my last visit*. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the MILLAR has already taken action in reliance on this consent;
9. I understand that if I revoke this consent at any time, MILLAR has the right to refuse to resign as my doctor and refer me to another provider. MILLAR is under no obligation for that referred provider to accept you as a patient;
10. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Millar Privacy Notice, then the MILLAR will not accept me as a patient and is immediately relieved from all obligations.

I have read and understand the above HIPAA Agreement, and all of my questions have been answered to my full satisfaction. I sign freely below.

_____	_____	_____
(Printed) Name of Patient	Signature of Patient	Date Signed

_____	_____	_____
Printed Name of Legal Representative*	Signature of Legal Representative	Date Signed

*Attorney-in-Fact, Guardian, Parent of Minor

_____	_____
Witness	Witness Date