Consent to the Use and Disclosure of Health Information For Treatment, Payment, or Healthcare Operations

Center for Complementary Medicine, Inc.

Lyn Swirda, Lic.Ac.

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and treatment information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I have read the Notice of Privacy Practices, have had the opportunity to ask questions regarding its content and meaning and fully understand its content and implication.

I understand that I have the right to review the notice prior to signing this consent.

I understand that the organization reserves the right to change their notice and practices and prior to implementation and will mail a copy of any revised notice to the address I've provided.

I understand that I have the right to object to the use of my health information for directory purposes.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operation and that the organization is not required to agree to the restrictions.

I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

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_____ _____

Signature of Patient or Legal Representative Date