# *Unbroken Flow Acupuncture, LLC*

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

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

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

I understand that I have the right to review the *Notice of Information Practices* prior to signing this document. The *Notice of Information Practices* describes in detail the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills, or in the performance of health care operations at Unbroken Flow Acupuncture, LLC. I understand that Unbroken Flow Acupuncture, LLC reserves the right to change their *Notice of Information Practices* at any time. I may obtain a revised *Notice of Information Practices* by requesting the most current notice during any office visit. 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 operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

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

Signature:_____ Name or minor:_____

Printed name:_____ Relationship:_____

Date:_____