THE ATLANTIC CENTER
FOR ACUPUNCTURE & ORIENTAL MEDICINE

Consent to the Use or Disclosure of my Protected Health Information for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by The Atlantic Center for Acupuncture and Oriental Medicine, LLC (known hereafter as TAC) for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bill or to conduct health care operations of TACAOM.

I understand that diagnosis or treatment of me by TAC may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. TACAOM is not required to agree to the restrictions that I may request. However, if TAC agrees to a restriction that I request, the restriction is binding on TAC.

I have the right to revoke this consent in writing, at any time, except to the extent that TAC has taken action in reliance of this consent.

My 'protected health information' means health information, including my demographic information, collected from me and created or received from my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review TAC's Notice of Privacy Practices prior to signing this document. TAC's Notice of Privacy Practices has been provided to me.

The Notice of Privacy Practices also describes my rights and the duties of TACAOM with respect to my protected health information.

TAC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or for asking for on at the time of my next appointment.

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Signature of Patient or Patient's Representative | Print Name of Patient's Representative

_____ _____

Date | Relationship or Authority of Representative