MOUNTAIN INTEGRATIVE MEDICINE, PLLC

# RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have reviewed a copy of Mountain Integrative Medicine, PLLC's Notice of Privacy Practices, version effective 7/1/2013. I consent to the uses and disclosures of my health information as outlined in the Notice and as below:

I consent to the disclosure of my protected health information by Mountain Integrative Medicine, PLLC for the purpose of providing treatment to me, obtaining payment for my health care bills and/or to conduct health care operations.

I understand I have a right to review Mountain Integrative Medicine, PLLC's Notice of Privacy Practices prior to signing this document. Mountain Integrative Medicine, PLLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice by accessing the practice website, calling the office and/or requesting that a revised copy be sent to me by mail.

I understand that I have a right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Mountain Integrative Medicine, PLLC is not required to agree to the restrictions that I request; however, if Mountain Integrative Medicine, PLLC agrees to a restriction that I request, that restriction is binding.

I have the right to revoke this consent in writing at any time except to the extent that Mountain Integrative Medicine, PLLC has taken action in reliance on this consent.

☐ I have read the Notice of Privacy Practices provided by Mountain Integrative Medicine, PLLC and agree to its terms.

_____ _____

Signature of Patient or Representative Date

_____

Print Name

_____

Relationship of Representative to Patient

If unable to obtain consent, please explain why: _____