PATIENT'S CONSENT FOR THE PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

I,_____, give consent to Essential Wellness of Illinois, LLC and Christine A. Renz, L.Ac. for the use and disclosure of my individual identifiable health information or protected health information for the specific purposes:

A. Providing treatment to me
B. Pertaining to the payment of the services this office has rendered to me
C. The general administrative operations this practice provides to me

The purpose of this consent:
Protected health information is any information including:

A. Demographic information
B. Information gathered by this practice as it relates to my past, present and future physical or mental health condition.
C. Information gathered by this office for past, present, or future payments providing the healthcare services.
D. Healthcare operations purposes will include quality assessment activities, credentialing, business management and other general operations procedures or activities.

I understand I have the right to request additional restrictions on the use and disclosure of my protected health information for the purposes of treatment and payment of healthcare operations of the Acupuncture practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice so long as it is in writing.

I understand I have the right to read and discuss the Notice of Privacy Policies and Procedures form this acupuncture practice uses before I sign this consent form regarding the use and disclosures of my protected health information.

I have the right to revoke this consent, in writing, at any time except to the extent that the acupuncturist or the Practice has acted in reliance on this consent.

_____Date_____
Signature of Patient or Personal Representative

_____Date_____
Description of Personal Representative's Authority