ADVANCED WELLNESS CENTER OF PA
Alternative Solutions to Chronic Health Problems

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PATIENT HEALTH INFORMATION CONSENT FORM

OUR PRIVACY PLEDGE 1

We are very concerned with protecting your privacy. While the law requires us to give you a copy of our Privacy Notice, please understand that we have and always will respect the privacy of your health information. At your request, we will give you a copy of our privacy notice. Advanced Wellness Center of PA does reserve the right to change our privacy practices as described in the notice. If any future changes are made to our privacy practices, we will notify you in writing.

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION 2

The following are possible circumstances in which we may have to send or disclose your Patient Health Information (PHI):

- We may have to discuss your PHI with another health care provider or hospital if necessary to refer you to them for diagnosis assessment or treatment of a health condition.
- We may have to disclose your PHI and billing records to another party (*i.e. insurance companies*) if they are responsible for the payment of your services.
- We may need to use your PHI within our office for quality control or other operational purposes.

Initials: _____

APPOINTMENT REMINDERS AND HEALTH CARE INFORMATION AUTHORIZATION 3

Authorized staff of Advanced Wellness Center of PA may need to use your name, phone number, billing information and clinical records to contact you with appointment reminders, information on treatment alternatives or other PHI. If this contact is made by phone and you are not home, a message will be left on your answering machine or voice mail. By signing this form, you are giving us authorization to contact you in this manner. As well, you may restrict the individuals or organizations to which your PHI is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and be mailed to our office. We will not be able to honor your revocation if we have already released your PHI before we receive your request to revoke your authorization. In addition, your authorization to give your PHI allows us to disclose information to your insurance company for verification or claim processing. You have the right to refuse to give us this authorization. If you do not give us this authorization, it will not affect the treatment we provide or the methods we use to obtain reimbursement for your care.

Permission to call at work:_____ Initials: _____

MAILING AUTHORIZATION 4

From time to time our office may mail you information to make you aware of special offers related to services or products, and events that may interest you. Your authorization is required for our office to mail the information about the following products and/or services to you: birthday cards, congratulations cards, food drives, newsletters, coupon books, brochures, surveys, and charity organizational drives.

Initials: _____

Information that we use to disclose based on authorization you are giving us may be subject to re-disclosure by the person who receives the information and may no longer be protected by federal privacy rules. This notice is effective from the date it is signed and will expire seven years after the date you last received services from us.

Initials: _____

I authorize you to disclose my health information in the manner described above. I have read this consent form and agree. I am also acknowledging that I received a copy of this consent form.

_____
Patient Name (Signature) Date

_____
Patient Name (Printed)

_____
Authorized Provider Representative (Signature) Date