MADISON
INTEGRATIVE MEDICINE

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

1. This is to inform you that Madison Integrative Medicine may use and disclose your health information that identifies you, and that consist of your past, present, or future physical or mental health condition. The provision of your healthcare: and the past, present or future payment for the provision of your healthcare (this health information is referred to herein as "PROTECTED HEALTH INFORMATION").

2. The use and disclosure of your protected health information will be to carry out treatment, payment, and healthcare operations for Madison Integrative Medicine.

3. You have the right to request that Madison Integrative Medicine be restricted from using or disclosing your protected health information in carrying out treatment, payment or healthcare operations; however Madison Integrative Medicine is not required to agree to your requested restrictions. If Madison Integrative Medicine does agree to your requested restrictions, then it will comply with your request.

4. You have the right to revoke this consent. This revocation must be made in writing to Madison Integrative Medicine. This revocation will be valid except to the extent that Madison Integrative Medicine has taken action in reliance on this consent.

Further, I hereby authorize and give my consent to Madison Integrative Medicine to communicate any of my protected health information to the following persons:

	Name:	Relationship:
1.		
2.		
3.		
4.		

_____ I, Acknowledge receipt of this notice of privacy practices from which details how protected health information may be used and disclosed, and how I may access that information.

_____ _____

Patient Name (Please print) Authorized Representative

_____

Patient Signature & Date