Alaskan Natural Care, Inc.

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

NAME _____

BIRTHDATE _____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to correspondence by e-mail.
- To object to reminder calls at work and/or at home.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested (however, we may not be able to bill insurance for you if this is restricted).
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

I request the following restrictions to the use of disclosure of my health information:

_____

_____

I give my permission to receive reminder calls at: □work □home □cell. _____ Initial

I give my permission to be contacted by: □mail □e-mail _____ Initial

I have read Alaskan Natural Care Inc.'s Notice of Privacy Practices.

Patient:

X_____ _____ _____

Patient Signature or Legal Representative **Date** **Witness Signature**

Office Use Only:

□ Accepted _____ _____ _____

□ Denied Signature Title Date