HIPPA Compliance Requirement

Patient Consent to the Use/Disclosure of Patient History Information
for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Elisa K. Wong L.Ac. originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

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

I understand that as part of this organization's treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity and I consent to such disclosure for these permitted uses, including disclosures via fax. A copy of the Notice of Information Practices is available upon request.

_____
Print Name of Patient

_____ _____
Signature of Patient Date

_____ _____
Authorized Facility Signature Date