South Boulder Healing Center, PLLC

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Consent for Purposes of Treatment, Payment and Healthcare Operations

I, _____ [Name of Individual] consent to South Boulder Healing Center, PLLC ("the Practice") use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practices' general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practices' diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practices, that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Practices, but the Practices are not required to agree to these restrictions. However, if the Practices agree to a restriction that I request, the restriction is binding on the Practices.

I understand I have a right to review the Practices' Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practices' duties regarding the types of uses 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 Physicians or the Practices has acted in reliance on this consent.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, [Individual's name] acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of South Boulder Healing Center, PLLC which describes the Practice policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practices.

**Please direct any questions to the office manager, Denise Haag*

_____ _____

Signature of Patient or Personal Representative Date

_____

Please Print the name of Patient/Personal Representative

_____

Description of Personal Representative's Authority