ACUPUNCTURE OF IOWA

PATIENT'S CONSENT TO USE INFORMATION FOR THE PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OFFICE OPERATIONS

In April of 2003, new federal requirements regarding privacy of information for health care patients took effect. H.I.P.P.A., the Health Insurance Portability and Protection Act requires that all providers, insurance companies and others, put in place controls to ensure that your personal and medical information is safe.

Acupuncture of Iowa requests that each patient sign this consent form which allows us to share protected health information with our administrative staff and your insurance company if applicable. By signing this form, you consent to our use of your protected health information for the purposes of your treatment, and administrative activities within our office. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. We will request a separate release in order to obtain medical records from your other providers and to share information outside this office.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. We have provided you a copy of this notice.

Your signature below indicates that you have read and agree to the above.

Patient Name: _____
(Please print)

Patient (or Representative) Signature: _____ Date: _____

Optional:
Authorization to release information to family members ____Yes ____ No

I authorize Acupuncture of Iowa to release only my clinical notes to the following family members:

1._____ Relation to Patient _____

2._____ Relation to Patient _____

Mandatory:
Authorization to leave messages regarding your appointment and related matters with household members and/or answering machine ____ Yes ____No

Patient Signature: _____ Date: _____