
**PATIENT CONSENT TO USE OR DISCLOSURE OF PERSONAL HEALTH INFORMATION**

I understand that I have the right to review Bouchard Wellness' Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices has been provided to me, _____.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information (PHI) that will occur in my treatment, payment of my bills or in the performance of healthcare operations of the agency. My "protected health information" means health information, including my demographic information (name, address, phone number, etc.), that is collected from me and created or received by my healthcare providers or health insurer. This PHI relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me. The Notice also describes other potential releases of my PHI that may occur with or without my authorization and my rights regarding my health information.

Elisabeth Bouchard at Bouchard Wellness reserves the right to change the privacy practices that are described in the Notice Bouchard Wellness will provide me with a copy of any revisions to the Notice. The Notice is posted in Bouchard Wellness' clinic reception area. I may obtain a revised Notice by calling the office and requesting a revised copy be sent in the mail or by asking for one at the time of my next visit.

I understand that I have the right to request restrictions on how PHI is used or disclosed to carry out treatment, payment, or the agency's healthcare operations. [Agency] is not required to agree to the requested restrictions. However, if there is agreement, the restriction is binding on [Agency] until the agreement is terminated.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations and acknowledge receipt of our Notice of Privacy Practices.

| _____ | _____ | _____ |
|---|---|---|
| Print Client or Personal Representative Name | Client or Personal Representative Signature | Date |

_____

Description of Authority of Personal Representative