HIPAA Consent Form
(Health Insurance Portability and Accountability Act)

I give "Teresa Jansen, AEMP, LAc" my consent to use or disclose my protected health information to carry out my treatment, to obtain payment, and for health care operations such as quality reviews.

I have been informed that I may review the clinic's Notice of Privacy Practices for a more complete description of uses and disclosures before signing the consent.

I understand that this clinic has the right to change their privacy practices and that I may obtain my revised notices at the clinic.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the clinic is not required to agree to the request. If the clinic agrees to my requested restriction, they must follow the restriction(s).

Complaints concerning my protected health information should be filed in writing with the clinic owner.

_____/_____/_____

Patient Name (Print) Patient or Guardian Signature Date

_____/_____/_____

Received By Date