Tree of Life Healing Center, LLC.
Dr. Cari Cater, Dipl.LAc
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Smyrna, GA 30080
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HIPPA PATIENT CONSENT PRIVACY USE & DISCLOSURE

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. This notice describes this office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

In order to maintain the level of service that you expect from this office, we may need to share limited personal medical and financial information with your insurance company, with Worker's Compensation, Attorneys or with other medical practitioners that you authorize. This would always be discussed with your prior to sharing.

*****I consent to such uses as permitted by law: Please Initial_____***

Safeguards at this office include:

- Limited access to where information is stored.
- Policies and procedures for handling information.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records are kept on permanent file for 7 years, as determined by law.

Types of information that we gather and use:

In administering your health care, we gather and maintain information that may include nonpublic personal information from:

- Your financial transactions with us (billing transactions).
- Your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
- Health care providers, insurance companies, workman's comp and other third party administrators (e.g. requests for medical records, claim payment information).

I understand that I may revoke this consent in writing, at any time, except to the extent that you have taken action relying on this consent.

I request the following restrictions to the use or disclosure of my health information (named below):

Please identify the name(s) of individuals we may discuss your health information with:

(Physician, family member, other healthcare practitioners, attorneys, etc.)

May we leave a message on your cell, work and/or home # using practitioner's name: yes no

*****I fully understand and *accept* or *decline* (circle one) the information of this consent.**

_____ _____
Patient or Legally Authorized Individual Signature Date

_____
Print Patient's Full Name

_____ _____
Witness Signature Date

*****Copy of this disclosure is available at patients request.**