CONSENT/AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PRIVACY PLEDGE: Firefly Acupuncture is concerned with and committed to the protection of our patients' and clients' privacy and ensuring the confidentiality of personal health information entrusted to us.

Ways in which the Firefly Acupuncture may use or disclose your health care information include, but are not limited to:
• Another party, such as an insurance carrier, HMO or employer for the purpose of receiving payment for services rendered to you.
• The use of that information within our practice for quality control or other operational purposes.
• Business associates that we contract with to perform a service for your benefit.
• The use of that information to contact you by telephone, mail or e-mail with appointment reminders, information about our clinic facilities, treatment alternatives or other health-related information that may be of interest to you.

Along with this consent form, you will be given a copy of our privacy notice that describes our privacy policies in detail. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. The current notice, including the effective date, will be posted in the clinic facility and will be given to you when you come in for treatment.

Your Right to Limit Uses or Disclosures: You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions; however, if we agree with your restrictions, the restriction is binding on us.

Your Right to Revoke Your Authorization: You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

YOU HAVE A RIGHT TO REFUSE CONSENT FOR DISCLOSURE OF YOUR PERSONAL HEALTH INFORMATION. WITHOUT YOUR CONSENT, HOWEVER, FIREFLY ACUPUNCTURE WILL NOT BE ABLE TO SUBMIT CLAIMS TO INSURANCE CARRIERS OR OTHER THIRD PARTY PAYERS AND MAY NOT ACCEPT YOU AS A PATIENT/CLIENT.

Initial here

[ ] I acknowledge receipt of the NWHSU-Notice of Privacy Practices

By signing below, I give consent to Firefly Acupuncture clinicians or staff to disclose my personal health information as noted above.

______________________	______________________
Printed Name	**Authorized Provider Representative**
______________________	______________________
Signature	**Date**
______________________	
Date	