HIPAA Agreement for Michelle Crowder, N.D.

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Michelle Crowder, N.D. to use and disclose my protected health information (PHI) to carry out treatment, payment and health care operations. I understand that the uses and disclosures by this office of my PHI are necessary and will be used in connection with my treatment and obtaining payment for treatment and services provided.

Patient Name:_____

Patient Date of Birth:_____

Guardian Name (if patient is under 18 years of age): _____

Below are methods in which we will contact you with test results and health information. Please list the options that Michelle Crowder, N.D. and staff are permitted to utilize:

Home phone: _____ Cell phone: _____

Email address: _____

Name of those to whom medical information may be disclosed:

1. _____ Relationship to patient:_____

2. _____ Relationship to patient:_____

I understand that in order for Michelle Crowder, N.D. to provide the best medical care possible I must follow the instructions included in this packet and to notify the office if I experience any problems with my treatment.

Initials: _____

I give my permission for Michelle Crowder, N.D. and staff to give any test results to the family member(s) of which I have listed above if I cannot be reached.

Initials: _____

I give my permission for Michelle Crowder, N.D. and staff to leave test results on the voicemail of the phone number listed above.

Initials: _____

I have been offered a copy of HIPAA regulations for my information.

Initials: _____

By signing this form, I am consenting to allow Michelle Crowder, N.D. to use and disclose my PHI to carry out health care services and payment.

Patient Signature (or guardian if patient is under 18 years of age):

_____

Date: _____