Patient Name: _____

Privacy Notice

We are very concerned about protecting your privacy. While the law requires us to give you this disclosure, please understand that we have respected and always will respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information:

- We may have to disclose your health information to another health care provider or a hospital as it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

You have a right to review our privacy policies in detail prior to signing this form. A copy is available at the office of Eckert Wellness Center. We reserve the right to change our privacy practices as described in that notice.

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 receiving 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.

I have read this consent policy and agree to its terms. I am also acknowledging that I have received a copy of this form.

Patient Signature: _____ Date: _____

Parent/Guardian: _____ Date: _____

Witness: _____ Date: _____