

Integrative Medicine Center/Paula Castro, M.D.

Patient consent to the use and disclosure of Protected Health Information (PHI) for treatment, payment and healthcare operations.

I understand that as part of my healthcare, Integrative Medicine Center/Paula Castro, MD originates and maintains paper and/ or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that information serves as:

- A basis for planning my care and treatment
- A means of communications among health professionals who may contribute to my care
- A source of information for applying my diagnosis and treatment to my account
- A means by which a third- party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality, clinical outcomes and reviewing the competence of healthcare professionals

I have received a copy of Integrative Medicine Center/Paula Castro, M.D. Notice of Privacy Practices that provides a detailed description of information of information uses and disclosure. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this document
- The right to request restrictions as to how my health information may be used or disclosed in the course of treatment, payment or healthcare operations
- The right to object to the use of my health information for directory purposes

I understand that Integrative Medicine Center/Paula Castro, M.D. are not required to agree to requested restrictions. I understand that I may revoke this consent in writing, except to the extent that Integrative Medicine center/Paula Castro, M.D. have already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, Integrative Medicine Center/Paula Castro, M.D. may refuse treatment as permitted by Section 164.506 of the Code of Federal Regulations. Should Integrative Medicine Center/Paula Castro, M.D. revise their Notice of Privacy Practices, a copy will be provided to me at my request.

I understand that as part of Integrative Medicine Center/Paula Castro, M.D. treatment, payment or health care operations, it may necessary to disclose my protected health information to another entity. I consent to such disclosure for these permitted uses, including disclosures via facsimile.

Patient Acknowledgement:

I acknowledge receipt of Integrative Medicine Center/Paula Castro, M.D. Notice of Privacy Practices.

Date
Printed Name

Signature