WESTERN WAKE WELLNESS

WESTERN WAKE WELLNESS, PLLC

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www.WesternWakeWellness.com

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

I hereby consent to the use or disclosure of my identifiable health information ("protected health information") by Western Wake Wellness in order to carry out treatment, payment, or health care operations. I have been given the opportunity to review Western Wake Wellness' Notice of Privacy Practices for Protected Health Information for a more complete description of the potential uses and disclosures of such information. I have the right to review such Notice prior to signing this consent form.

Western Wake Wellness reserves for itself the right to change the terms of its Notice of Privacy Practices for Protected Health Information at any time. If Western Wake Wellness does change the terms of its Notice of Privacy Practices, you may obtain a copy of the revised Notice by requesting the Notice from the Front Office Staff of Western Wake Wellness.

I retain the right to request that Western Wake Wellness further restrict how my protected health information is used or disclosed to carry out treatment, payment, or health care operations. Western Wake Wellness is not required to agree to such requested restrictions; however, if Western Wake Wellness does agree to my requested restriction(s), such restriction(s) are then binding on Western Wake Wellness.

At all times, I retain the right to revoke this Consent. Such revocation must be submitted to Western Wake Wellness in writing. The revocation shall be effective except to the extent that Western Wake Wellness has already taken action in reliance on the Consent. Western Wake Wellness may refuse to treat you if you do not sign this Consent Form (except to the extent that Western Wake Wellness is required by law to treat individuals). If you (or authorized representative) sign this Consent Form and then revoke consent, then Western Wake Wellness has the right to refuse to provide further treatment to you as of the time of revocation (except to the extent that the Facility is required by law to treat individuals).

I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE PATIENT, OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS SEALED DOCUMENT VERIFYING CONCENTER TO THE ABOVE STATED TERMS.

_____ _____ _____

Print Name of Patient/Responsible Party **Signed** **Date**

<u>Authorization for Appointment Reminders and Phone Consent</u>

I authorize the physicians and staff of Western Wake Wellness to:
(Please circle to indicate your preference, and list the preferred phone number)

- Send an appointment reminder via text message? NO YES Tel #_____ Carrier_____
- Send an appointment reminder via email? NO YES Email: _____
- Leave a voicemail message on my on Home/Cell Phone? NO YES Tel #_____
- Discuss my medical information with a member of my household? NO YES Tel #_____

  If yes, whom _____ Relationship _____