

# Healing Integrations

## Patient Information Consent Form

I have read and fully understand **Healing Integrations'** Notice of Information Practices. I understand that **Healing Integrations** may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of services provided, and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that **Healing Integrations** will consider requests for restrictions on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in **Healing Integrations'** Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

**Patient Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

## Designated Individuals Authorization Form

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

### Authorized Designee

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**It is acceptable to leave a message for you at (check all that apply):**

Home    Work    Cell phone    Pager

**Patient Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_