HIPPA—CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

1. Permission to Use and Disclose My Health Information. By signing this form, I give Josephine Lee, MS, DC, permission to use and/or disclose my health information to carry out treatment, payment or health care provisions.

2. Right to Refuse. I have the right not to sign this consent. If I refuse to sign this consent, Josephine Lee, MS, DC, will not provide me with treatment until I consent. However, treatment required by law, such as emergency care, can be provided to me whether or not I sign this consent.

3. Right to Review Notice of Privacy Practices. Josephine Lee, MS, DC has provided me with a copy of their Notice of Privacy Practices which describes how Josephine Lee, MS, DC may use and disclose my health information. I have the right to review this Notice before signing this consent.

4. Changes to the Privacy Notice. Josephine Lee, MS, DC may change the Notice of Privacy Practices as needed. I may obtain a current copy of Josephine Lee, MS, DC's Notice of Privacy Practices by contacting Dr. Josephine Lee, MS, DC.

5. Right to Request Restrictions on Use/Disclosure. I have the right to request that Josephine Lee, MS, DC restrict how she uses and/or discloses my protected health information for the purpose of providing treatment, obtaining payment for services, and/or conducting health care operations. Josephine Lee, MS, DC is ***not required*** to agree to any restriction I request. If Josephine Lee, MS, DC does decide to agree to my request, she must restrict their use and/or disclosure of my health information the way I had asked. Because of the number, complexity, and nature of the services they deliver, Josephine Lee, MS, DC will rarely agree to requests to restrict uses and disclosures of my health information for the purposes of treatment, payment, and healthcare operations. If I wish to request restrictions I can contact Dr. Josephine Lee. Josephine Lee, MS, DC will notify me of her decision to accept or decline my restrictions.

6. Right to Withdraw Consent. I have the right to withdraw this consent at any time. I must do this in writing. If I want to withdraw this consent, I can contact in writing Dr. Josephine Lee, MS, DC at 11384 Baugher Town Rd, Richwoods, MO 63071. Note that my withdrawal of this consent will ***not*** be effective for uses and/or disclosures that have already been made based on my prior consent. If I withdraw this consent, then Josephine Lee, MS, DC, by law, is unable to provide to me further treatment or follow-up, other than required emergency services*.*

7. Effective Period. This consent is good unless and until I withdraw it in writing.

8. References to "I" or "me". References to "I" or "me" in this Consent include the individual for whom the signing party is authorized to sign. If I am signing this consent on behalf of another person, it is because I am the legal guardian, parent, or agent under an active Power of Attorney for Health Care, and am legally authorized to sign this Consent on behalf of the individual.

Patient Signature:_____
Date:_____