Golden Oak Acupuncture
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Golden Oak Acupuncture & Herbal Medicine

"Root, Revive & Thrive"

HIPAA Consent Form

I give Golden Oak Acupuncture my consent to use or disclose my, or my child's (if patient is a minor), protected health information to carry out the treatment, to obtain payment, and for health care operations such as quality reviews.

I have been informed that I may review the clinic's Notice of Privacy Practices for a more complete description of uses and disclosures before signing this consent.

I understand this clinic has the right to change their privacy practices and that I may obtain my revised notices at the clinic.

I understand that the practitioners are required to keep my personal and medical information confidential and that prior to any communication with another provider regarding my personal or medical information I must sign a release form for both providers before any information may be communicated.

I understand I have the right to request a restriction of how my protected heath information is used. However, I also understand that the clinic is not required to agree to the request. If the clinic agrees to my requested restriction, they must follow the restriction(s).

I understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed. Complaints concerning my, or my child's (if patient is a minor) protected health information should be filed in writing with the Clinic Director.

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Patient's or Guardian's Name and Signature Date