

## Consent for Purposes of Treatment, Payment & Healthcare Operations

I consent to the use or disclosure of my protected health information by Grateful Health & Wellness for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Grateful Health & Wellness. I understand that analysis, diagnosis or treatment of me by Grateful Health & Wellness may be conditioned upon my consent as evidenced in my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Grateful Health & Wellness is not required to agree to the restrictions that I may request. However, if Grateful Health & Wellness agrees to a restriction that I request, the restriction is binding on Grateful Health & Wellness.

I have the right to revoke this consent, in writing, at any time, except to the extent that Grateful Health & Wellness has taken action in reliance on this Consent.

My “protected health information” means health information, including my demographic information collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe that information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Grateful Health & Wellness and understand that I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Grateful Health & Wellness. This Notice of Privacy Practices also describes my rights and duties of Grateful Health & Wellness with respect to my protected health information.

Grateful Health & Wellness reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Grateful Health & Wellness and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

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Signature of Patient/Personal Representative

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Printed Name of Patient

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Description of Personal Representative’s Authority  
*(if applicable)*

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Date of Signing