Healing Path Holistic Medicine Clinic
3880 SE Harrison Street
Milwaukie, OR 97222
Phone 503 513 4665
Fax: 503 513 4663

Anja Middelveld, L.Ac.MAc.OM.

I, _____, consent to the use or disclosure of my protected health information by Anja Middelveld, L.Ac. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care operations of Anja Middelveld, Lac. I understand that diagnosis or treatment of me by Anja Middelveld, L.Ac may be conditioned upon my consent as evidenced by my signature on this document.

I understand that 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 the health care operations of the practice. Anja Middelveld, L.Ac is not required to agree to the restrictions that I may request, however, if Anja Middelveld, L.Ac. agrees to a restriction that I request, that restriction is binding.

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 clearing house. This protected health information is information related to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe this information identifies me.

I understand that I have a right to review Healing Path Holistic Medicine Clinics notice of Privacy Practices prior to signing this document and a copy of the Privacy Practices document has been provided to me. The notice of Privacy Practices describes the type of uses and disclosures of my protected health information that will occur in my treatment, payment of bills, or in the performance of health care operations of Anja Middelveld, L.Ac. with respect to my protected health information.

Anja Middelveld, L.Ac. 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 contacting the HIPPA representative at the office and requesting a revised copy be sent in the mail or by asking for one at the time of my next appointment.

Anja Middelveld, L.Ac. reserves the right to leave a message on the patient's home answering machine/recorder. As the patient, I consent to this right.

I understand that if I, the patient, refuse to sign this consent form, my health care information cannot be given to insurance companies, and consequently, I, the patient, will be responsible for the entire bill and will be billed accordingly.

_____ _____
Signature of Patient or Personal Representative Name of Patient or Personal Representative

_____ _____
Description of Personal Representative Authority Date