The Vine Wellness Group - HIPAA ACT INFORMATION

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

I consent to the use or disclosure of my protected health information by The Vine Wellness Group, LLC for the purpose of diagnosing or providing treatment to me, obtaining payment of my health care bills, or to conduct health care operations of The Vine Wellness Group, LLC. I understand that diagnosis or treatment of me by a TVWG provider 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 healthcare operations of the practice. TVWG is not required to agree to the restrictions that I may request. However, if TVWG agrees to a restriction that I request, the restriction is binding on TVWG.

I have the right to revoke this consent, in writing, at any time, except to the extent that TVWG 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 condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review The Vine Wellness Group's Notice of Privacy Practices prior to signing this document. TVWG's Notice of Privacy Practices has been provided to me. 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 in TVWG's practice.

TVWG/Annie Viers or Celeste Inman 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 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 or Personal Representative

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Name of Patient or Personal Representative

Date _____

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Description of Personal Representative's Authority