

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

I consent to the use or disclosure of any protected health information by Dr. Eliza Kim, D. C. for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of Hands of Life Hawaii, Inc. I understand that diagnosis or treatment of me by Dr. Kim may be conditioned upon my consent as evidenced by my signature on this document.

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. Dr. Kim is not required to agree to the restrictions that I may request. However, if Dr. Kim agrees to a restriction that I request, the restriction is binding on \_\_\_\_\_ (date).

I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Kim has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and collected or received by my physician, another healthcare provider, a health plan, my employer or a healthcare 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 this information may identify me.

I understand I have the right to review HIPAA Notice of Privacy prior to signing this document. The HIPAA Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosure of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations of Hands of Life Hawaii.

This Notice of Privacy Practices also describes my rights and the Doctor's duties with respect to my protected health information.

HIPAA 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 requesting a revised copy by sent in mail or asking for one at the time of my next appointment.

*Office use:*

*I authorize Dr. Eliza Kim to consult with \_\_\_\_\_  
(practitioner's name) pertaining to my condition. \_\_\_\_\_ (initials) \_\_\_\_\_ (date).*

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient or Personal Representative