Rising Phoenix Integrative Medicine Center

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **all current and future independent clinicians and health care providers practicing at Rising Phoenix Integrative Medicine Center, with current clinicians named as Michael Cantwell, MD, MPH, Melissa Congdon, MD, Helen Ye, MS, LAc, Theresa Garcia, CMT, Victoria Dudas, PharmD, Ingrid Foster, RMT, SMT, ATP** to use and disclose protected health information (PHI) about me to carry out diagnosis, treatment, payment and health care operations (TPO).

The Notice of Privacy Practices provided by **my clinician(s) at Rising Phoenix Integrative Medicine Center** describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. **All independent clinicians working in the Rising Phoenix Integrative Medicine Center** reserve the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **HIPAA Information Request at Rising Phoenix Integrative Medicine Center, 815 Hyde Street, Suite 317, San Francisco, CA 94109**.

With this consent, independent clinicians/health care providers of Rising Phoenix Integrative Medicine Center may email me at the email address(es) I have on file, or send text messages to my mobile phone, call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, independent **clinicians and health care providers practicing at Rising Phoenix Integrative Medicine Center** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, **independent clinicians/health care providers of Rising Phoenix Integrative Medicine Center** may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, responses to my questions, and patient statements. I have the right to request that **independent clinicians/healthcare providers within Rising Phoenix Integrative Medicine Center** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **all current and future independent clinicians and healthcare providers who work within Rising Phoenix Integrative Medicine Center** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **independent clinicians/health care providers of Rising Phoenix Integrative Medicine Center** may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian | Print Name of Patient or Legal Guardian, if applicable

_____ _____

Print Patient's Name | Date