# Consent to Collect, Use, and Disclose Personal Health Information

I, _____,or my substitute decision-maker_____
Print name Print name if applicable

**consent** for Clinic **Chippawa Therapeutics** to collect, use and disclose my personal health information for the purpose of providing traditional Chinese medicine/acupuncture or massage therapy to me and for the related purposes set out in **Chippawa Therapeutics'** Written Privacy Statement.
The personal health information that may be collected, used or disclosed by the Clinic may include the following, among other things:

- my birth date and contact information
- my health history and family health history
- my health status
- the health care I receive (including identifying my health care provider(s));
- my health number
- the identification of my substitute decision-maker, if any
- insurance or billing information relating to health care

I understand that there may be situations in which practitioners at **Chippawa Therapeutics** will have to collect, use or disclose personal health information without my consent, but that they will only do this if permitted by law.

**How My Information Will Be Used**
I understand that my personal health information may be collected, used or disclosed for the following reasons:

- To provide me with traditional Chinese medicine/acupuncture or massage therapy services
- To obtain payment for services provided
- To assist insurance companies with insurance claims verification
- To seek advice for potential treatment options
- To provide or arrange health care in cases of emergencies
- To fulfill any obligations as mandated by law

**Patient Access to Information**
I understand that my personal health information is available to me for my review except in limited circumstances as permitted by law. I also understand that I can ask to have my personal health information corrected if I believe there is a mistake in the records, with some exceptions.

**Acknowledgment**
I allow **Chippawa Therapeutics** to collect, use and disclose my personal health information as outlined above.
I understand that I can access my personal health information with some limited exceptions.
I understand that I am not required to sign this form and that I can withdraw my consent at any time by contacting **Chippawa Therapeutics**, but it may directly affect the services I can receive. My personal health information may still be collected, used or disclosed if permitted by law.

**Additional Comments or Restrictions:**

_____

_____

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____