Absolute Balance Acupuncture Clinic

25-15 Fair Lawn Avenue, Fair Lawn, NJ 07410
Phone: 201-916-0509; Fax: 201-815-2073

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Absolute Balance Acupuncture Clinic, LLC, T. Volin, L. Ac., Dipl. OM. (NCCAOM) to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Absolute Balance Acupuncture Clinic, LLC describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent.

Absolute Balance Acupuncture Clinic, LLC. reserves 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 Taya Volin L.Ac.

With this consent Absolute Balance Acupuncture Clinic, LLC. may 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, Absolute Balance Acupuncture Clinic, LLC 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 as long as they are marked "Personal and Confidential."

With this consent, Absolute Balance Acupuncture Clinic, LLC 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 and patient statements. I have the right to request that Absolute Balance Acupuncture Clinic, LLC 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 Absolute Balance Acupuncture Clinic, LLC 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, Absolute Balance Acupuncture Clinic, LLC. may decline to provide treatment to me.

_____

PATIENT's /GUARDIAN SIGNATURE

_____ _____

PRINT PATIENT'S NAME DATE