HIPPA Form

Doctors Best Wellness Center

Consent for Purposes of Treatment, Payment & Healthcare Operations (3/03)

In this document, "I" and "my" refer to the patient, and "Physician" refers to Dr. Manocchio and / or his associates. I consent to the use of disclosure of my protected health information by Physician for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Physician. I understand that analysis, diagnosis or treatment of me by my Physician may be conditioned upon my consent as evidenced by my signature below.

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 or healthcare operations of the practice. Physician is not required to agree to the restrictions that I may request. However, if Physician agrees to a restriction that I request, the restriction is blinding on Physician.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician 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 information relates to my past, present, or future physical or mental health or condition that identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Physician and understand that I have a right to review the Notice of Privacy Practices prior to signing this document. 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 operation of a Physician. The Notice of Privacy Practices for Physician is also posted in the waiting room at 5542 Flamingo Road. This Notice of Privacy Practices also describes my rights and duties of the Physician with respect to my protected health information.

Physician 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 of Physician and requesting a revised copy be sent to me in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative | Printed Name of Patient

_____ _____

Date of Signing | Description of Personal Representative's Authority (parent/guardian)