KOALA HEALTH AND WELLNESS CENTERS, INC.
1600 SMITH STREET STE 4225 HOUSTON, TX 77002
713-652-9777

Consent to use PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by KOALA HEALTH AND WELLNESS CENTERS, INC., or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights concerning the limited use of your health information, including your demographic information, collected from you and created or received by this office.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas

Please be advised that some or all of your treatment may be received in an open area. If you wish to receive treatment in a private setting, please notify the staff immediately.

Waiver of Itemized Statements

You have the right to request a fee schedule and an itemized receipt. We post payments into accounts at the end of our business day and can provide a payment receipt the next day. Please know that we do post all charges into each patient's account at the end of every business day. If you would like to receive an itemized receipt, please let the front desk know on the date of service, so that the following business day you may pick up the form, or opt to have it sent electronically to you.

Revocation of Consent

If you choose to revoke this consent, you must do so in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

Patient's (or Legally Authorized Individual's) Signature _____ Date _____

Print Patient's Full Name _____ Witness Signature _____ Date _____

Patient was offered a copy of our privacy policy and did not take it. ____Patient Initials

Patient was offered a copy of our privacy policy and accepted it. ____Patient Initials

Patient was emailed a copy of OR accepted the HIPAA Privacy Policy on our website. ___Initials