HIPAA NOTICE

I have read the Privacy Notice and understand my rights as stated in the Notice.

I hereby provide Natural Wellness Care Center with my authorized consent to use and disclose my private health care information for the purposes of treatment, health care operations, and payment.

____
Patient's Name (print)

____ __________________
Patient's Signature Date

____ __________________
Authorized Facility Signature Date

This notice is effective as of: _____/_____/______

If you are not satisfied with the manner in which this office sustains privacy practices, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201