

Consent to Use or Disclose Health Information

By signing this form I consent to the use or disclosure of my Protected Health Information (PHI) by Mindfulness, its staff and business associates for the purposes of treatment, payment, and healthcare operations. This is a joint consent form of Mindfulness and its clinical staff.

Protected Health Information (PHI) means health information (including identifying information about me) collected from me or received by Mindfulness, another provider, a health plan, my employer or a health care clearinghouse. It may include information about my past, present or future physical or mental health or condition, the provision of my health care and payment for my health services.

Mindfulness agrees to maintain my PHI in accordance with the practices described in the Mindfulness Privacy Notice. This notice also describes my rights with respect to the use and disclosure of my PHI. I acknowledge that I have been given a copy of the Mindfulness, LLC Privacy Notice and I have been given an opportunity to review the Mindfulness Privacy Notice prior to signing this consent.

I understand that this information may be needed to:

- Plan my care and treatment
- Communicate among the various health care professionals involved in my care
- Provide information to my health insurance company or plan
- Obtain payment from my health insurance company or plan
- Assess the quality of my care and review the care provided by my provider and other staff

I understand I have the right to refuse to sign this consent. Refusing to sign this consent will not prevent me from receiving care from Mindfulness.

I also understand I have the right to refuse to sign this consent, in writing, at any time, except to the extent that Mindfulness has taken action in reliance upon this consent. I further understand that I have the right to request a restriction as to how my PHI is used or disclosed to carry out treatment, payment or health care operations of Mindfulness. I realize that Mindfulness is not required to agree to a restriction that I may request. However, if Mindfulness does agree, the restriction must be honored by Mindfulness.

This consent expires at the termination of my treatment contract with Mindfulness.

Client/Guardian Signature

____/____/____
Date of Signature

Staff Signature

____/____/____
Date of Signature

Withdrawal of Consent: This consent is revoked on the date of

____/____/____
Date of Withdrawal

Client/Guardian Signature

____/____/____
Date of Signature

Staff/Witness Signature

____/____/____
Date of Signature