Northwest Wellness Center

Release and Use of Confidential Information

I, ______________________________, hereby give my consent to Rehabilitation
(Name of Patient or Authorized Agent)
Associates of the Midwest, S.C. dba Northwest Wellness Center to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of ____________________________.
(Patient's Name)

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available upon my next office visit.

Signed: ____ Date: ______________________

Receipt of Notice of Privacy Practices Form

I, ______________________________, hereby acknowledge receipt of the physician's
(Patient's Name)
Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the notice. I also understand that a copy of any revised notice will be provided to me or made available.

Signed: ____ Date: ______________________

If you are not the patient, please specify your relationship to the patient ___________________.

– Patient's file