Karma Wellness Center
242 N Main Street New City, NY 10956
845-825-3362

HIPAA COMPLIANCE PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

This notice contains a patient's rights section describing your rights under aw. You ascertain that by your signature you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of information for treatment, payment or healthcare operations.

By signing this for I understand that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of information but the practice does not have to agree with those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or text to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell?	YES	NO
May we discuss your medical conditions with any member of your family?	YES	NO

If yes please list the members allowed:

1.) _____

2.) _____

3.) _____

This consent was signed by:_____
(PRINT NAME)

Signature: _____ Date: _____

Witness: _____ Date: _____