



Patient Consent for Use and Disclosure of Protected Health Information

Nurture LLC and its Providers create and maintain related records that include personal healthcare information including health records, symptoms, demographic information, diagnoses, examination and test results, treatment, and plans for future care or treatment. This is called “protected health information.”

I understand and consent to the use and disclosure of my protected health information by Nurture LLC to carry out treatment, payment, and health care operations (TPO) including:

- ❖ **Treatment.** This includes the provision, coordination, or supervision of my healthcare and related services, including the coordination or management of my care and consultation between healthcare professionals related to my treatment, or my referral to another healthcare professional.
- ❖ **Payment for healthcare services provided to me.** This includes actions undertaken by a health plan to decide coverage or the provision of benefits to me, by my Provider or a health plan to obtain or provide compensation for my care, or otherwise related to me.
- ❖ **Healthcare Operations.** This includes quality assessment and improvement activities; reviewing provider performance and training; activities relating to health insurance and benefits; conducting or arranging for medical review, legal services, and audits; business planning and development; and business management and general administrative activities.

I understand and agree that:

- ❖ I have the right to review Nurture LLC’s Notice of Privacy Practices prior to signing this Consent. The notice provides a more detailed description of the uses and disclosures of my protected health information. Nurture LLC reserves the right to revise the Notice of Privacy Practices at any time and I have the right to obtain a revised notice: a) online at NatureFunctionalMedicine.com on Forms and Fees page or by calling the office and requesting a copy, or c) asking for a copy at my next appointment.
- ❖ I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations. I understand and agree that Nurture LLC is not required to agree to any restrictions that I may request, but if Nurture LLC agrees, it will be bound by that restriction.

- ❖ I may revoke my consent in writing except to the extent that Nurture LLC has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Nurture LLC may decline to provide treatment to me.

With this consent, I agree that Nurture LLC and providers may contact me by phone, voicemail, or mail at primary and alternate locations/addresses I have designated. Email may also be used if I execute Nurture’s Email Policy and Consent document. I understand all of these channels will assist in communications pertaining to my questions, laboratory test results, patient statements, insurance requests, appointment reminders, and practice announcements, among others.

By signing this form, I am consenting to allow Nurture LLC to use and disclose my protected health information to carry out its TPO activities.

Patient (or Legal Guardian) Signature

Date

Patient Name

Legal Guardian Name (if applicable)