Anti-Aging & Wellness Center

276 S. Mill Street, Ste C
Tehachapi, CA 93561

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT AND CONSENT FORM

I understand that, under the health insurance portability and accountability act of 1996 (HIPAA), I have the right to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

- Obtain payment from third-party payers.

- Contact normal healthcare operations, such as the business aspects of running the practice on a daily basis.

I have received, read, and understand the Notice of Privacy Practices, containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to apply by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Patient signature: _____ Date: _____

Witness: _____ Date: _____

Witness's Relationship to the Patient: _____