



**HIPAA Notice of Privacy Practices and Consent/Written Acknowledgement**

I hereby consent to the use and disclosure of my protected health information by Wildflower Natural Medicine for the purposes of treatment, payment and healthcare operations, or as otherwise required by law.

- I acknowledge that I have a right to review or receive a printed copy of the Notice of Privacy Practices provided by Wildflower Natural Medicine prior to signing this consent. The Notice of Privacy Practices describes how medical information about me may be used and disclosed, and how I can access this information.
- I have the right to request restrictions to the usage and disclosure of my protected health information.
- I have the right to request an alternative to the standard method of communication of my protected health information.
- I understand that if I wish to revoke this consent at any time I will do so in writing and submit to the address listed below. I understand that Wildflower Natural Medicine may honor these requests, they are not required by law to do so. I also understand that revocations will be honored as of the date they are received by Wildflower Natural Medicine at the following address:

1516 SE 43<sup>rd</sup> Avenue, Suite 4  
Portland, OR. 97215

- I understand that if I have any questions or complaints I may submit them in writing to the address above or contact Wildflower Natural Medicine by phone at: 503-974-4813
- I am aware that Wildflower Natural Medicine reserves the right to change the terms of their Notice of Privacy Practices and to make new notice of Privacy Practices provisions effective for all protected health information that they maintain. In the event of amendments, Wildflower Natural Medicine will make available a revised Notice of Privacy Practice for my review.

\_\_\_\_\_  
Patient (18 years or older)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent, Guardian, or Responsible Party



**THIS SECTION IS TO BE COMPLETED BY PREMA HEALTH IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGEMENT FROM PATIENT**

I made a good faith effort to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

- Patient declined to sign this Written Acknowledgement
- Other (specify):

\_\_\_\_\_  
Name and title of employee

\_\_\_\_\_  
Date