

SASTUN CENTER OF INTEGRATIVE HEALTH CARE

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

In the interest of patient/client privacy and new federal regulations, we are updating our files and seeking your preferences in how you wish for us to communicate with you. (Please refer to the Sastun Center's Notice of Privacy Practices for a more complete description of such uses and disclosures.)

NAME: _____
PLEASE PRINT CLEARLY

Date of Birth: _____

CURRENT ADDRESS: _____

CITY: _____ ZIP: _____

May we mail sealed envelopes carrying our return address to this address?

YES _____ NO _____

Current telephone numbers:

HOME () _____

WORK () _____

HOME FAX () _____

MOBILE () _____

May we contact you personally with health related information, appointment reminders, etc. at the above numbers?

HOME Yes _____ No _____

WORK Yes _____ No _____

FAX Yes _____ No _____

MOBILE Yes _____ No _____

May we **leave a message** at the above numbers?

HOME: Yes, on answering machine _____
Yes, to family members/roommates in my absence _____
NO, do not leave messages here _____

WORK: Yes, on voicemail _____
Yes, with a coworker _____
NO, do not leave messages here _____

MOBILE: Yes, on voicemail _____
NO, do not leave messages here _____

FAX: Yes _____
NO _____

(over)

Do you have an E-mail address you would like us to use for appointment confirmation, messages related to health, etc? _____

Please print clearly

Would you like to receive our quarterly newsletter via E-mail?

_____ E-mail preferred address _____

Please print clearly

I understand that the Sastun Center has a Notice of Privacy Practice available to me for review. By signing this form, I am consenting to the Sastun Center's use and disclosure of my Protected Health Information to carry out Treatment, Payments or Operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, the Sastun Center may decline to provide treatment to me.

Signature

Date

Printed name

Form to be distributed to any/all of the practitioners you indicate below:

- | | |
|---|--|
| <input type="checkbox"/> Jane L. Murray, MD | <input type="checkbox"/> Celtina Reinert, Pharm. D
Integrative Pharmacist |
| <input type="checkbox"/> Cynthia Chamberlain
Acupuncture/Chinese Medicine
Eastern Healing Solutions | <input type="checkbox"/> William Hale, MD (Psychiatrist) |
| <input type="checkbox"/> Mehdi Khosh, ND | <input type="checkbox"/> Deena Beneda, ND |
| <input type="checkbox"/> Art Kent, Craniosacral Therapy | <input type="checkbox"/> Ursula Gilkeson,
Transformative Energy Healing |
| <input type="checkbox"/> Tamara Coder Mikinski, PhD | |
| <input type="checkbox"/> Karen Ialapi, RD, LD, CDE
Nutrition and Wellness Coaching | |