CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

1. Permission to Use and Disclose My Health Information. By signing this form, I give Matthew Fisel, ND permission to use and/or disclose my health information to carry out treatment, payment or health care operations.

2. Right to Refuse. I have the right not to sign this consent. If I refuse to sign this consent, Matthew Fisel, ND will not provide me with treatment until I consent. However, treatment required by law, such as emergency care, can be provided to me whether or not I sign this consent.

3. Right to Review Notice of Privacy Practices. Matthew Fisel, ND has provided me with a copy of their Notice of Privacy Practices which describes how Matthew Fisel, ND may use and disclose my health information. I have the right to review this Notice before signing this consent.

4. Changes to the Privacy Notice. Matthew Fisel, ND may change the Notice of Privacy Practices as needed. I may obtain a current copy of Matthew Fisel, ND's Notice of Privacy Practices by contacting Dr. Matthew Fisel.

5. Right to Request Restrictions on Use/Disclosure. I have the right to request that Matthew Fisel, ND restrict how he uses and/or discloses my protected health information for the purpose of providing treatment, obtaining payment for services, and/or conducting health care operations. Matthew Fisel, ND is ***not required*** to agree to any restriction I request. If Matthew Fisel, ND does decide to agree to my request, he must restrict their use and/or disclosure of my health information the way I asked. Because of the number, complexity, and nature of the services they deliver, Matthew Fisel, ND will rarely agree to requests to restrict uses and disclosures of my health information for the purposes of treatment, payment, and healthcare operations. If I wish to request restrictions I can contact Dr. Matthew Fisel. Matthew Fisel, ND will notify me of his decision to accept or decline my restrictions.

6. Right to Withdraw Consent. I have the right to withdraw this consent at any time. I must do this in writing. If I want to withdraw this consent, I can contact Dr. Matthew Fisel at 35 Boston St., Guilford, CT, 06437. Note that my withdrawal of this consent will ***not*** be effective for uses and/or disclosures that have already been made based on my prior consent. If I withdraw this consent, then Matthew Fisel, ND, by law, is unable to provide to me further treatment or follow-up, other than required emergency services.

7. Effective Period. This consent is good unless and until I withdraw it in writing.

8. References to "I" or "me". References to "I" or "me" in this Consent include the individual for whom the signing party is authorized to sign. If I am signing this consent on behalf of another person, it is because I am the legal guardian, parent, or agent under an active Power of Attorney for Health Care, and am legally authorized to sign this Consent on behalf of the individual.

Patient Signature:_____

Date:_____