Health Insurance Portability & Accountability Act of 1996 (HIPAA)

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1) Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
2) Obtain payment from third-party payers.
3) Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by the agency of the Notice of Privacy Practices containing a more complete description of the uses and disclosure of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that Move Well LLC has the right to change their Notice of Privacy Practices from time to time and that I may contact Move Well LLC at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that Move Well LLC restricts how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that Move Well LLC is not required to agree to my requested restrictions, but if the owner does agree then they are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that Move Well LLC has taken action relying on this content.

Patient or Patient's Guardian, signature:

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Relationship (state if self):

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☐ I agree to terms listed and all information provided is accurate.