HIPPA FORM

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by AAACOR for diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of AAACOR. I understand that diagnosis or treatment of me by AAACOR may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. AAACOR is not required to agree to the restrictions that I may request. However, if AAACOR agrees to a restriction that I request, the restriction is binding on AAACOR and William A. Lanting MD.

I have the right to revoke this consent, in writing, at any time, except to the extent that AAACOR has acted in dependence on this consent.

My “protected health information” means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review AAACOR, Notice of Privacy Policies prior to signing this document. The AAACOR, Notice of Privacy Policies has been provided to me. The Notice of Privacy Policies describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the AAACOR. The Notice of Privacy Policies for AAACOR, is also provided at 1029 Robertson St. Fort Collins, CO 80524 or 8223 W. 20th ST Suite B, Greeley CO. 80634 This Notice of Privacy Policy also describes my rights and the AAACOR’S duties with respect to my protected health information.

AAACOR reserves the right to change the privacy policies that are described in the notice of Privacy Policy. I may call the office and request a revised copy be sent to me in the mail or by asking for one at the time of my next appointment.

I_____________________________, give permission to let the AAACOR staff leave medical information in a message on my voice mail. Please list phone number:_________________________________.

☐ I give AAACOR permission to take my photo for my medical chart.

<table>
<tr><td>Signature of patient or Guardian:

X</td><td rowspan="4">If patient is a CHILD, please list other contacts that can accompany your child or Medical information can be disclosed to. If you as an ADULT would like to give permission to anyone to be allowed to discuss your medical information, list them here:
NAME AND RELATION TO PATIENT/PHONE #:

1. Name:____________________________

Phone #:__________________________

2. Name:____________________________

Phone #:__________________________</td></tr>
<tr><td>Date:</td></tr>
<tr><td>Email Address: (for current medical information, newsletters, and patient communication)</td></tr>
<tr><td>Printed name of patient or Guardian:

X</td></tr>
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