Rhythm of Health, Inc.
Because great health is a choice

8160 Coller Way, Suite A
Woodbury, MN 55125
(651) 208-1084
www.rhythmofhealth.com

Authorization for Use and Disclosure of Protected Health Information

We are very concerned with protecting your privacy. While the law requires that you give us this disclosure, please understand that we have, and always will, respect the privacy of your health information. There are several circumstances in which we may have to use or disclose your health information:

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

Along with this consent form, we have a more complete notice (Notice of Privacy Practices) that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. The current notice of privacy practices is posted on our web site at www.rhythmofhealth.com or is available any time by calling the clinic .

I authorize Rhythm of Health, Inc. to contact me with information related to my personal health needs and interests. The clinician and office staff may use any phone number or email in my personal records to contact me. If contact is made by phone and I am unable to respond, a message may be left with my home answering machine or voice mail service. I may be contacted about the following:

- Appointment reminders or schedule changes.
- Information about alternative treatments, presentations or events
- Other health related information that may be of interest to me

To contact me, I authorize Rhythm of Health, Inc. to use and disclose the following information:

- My name, address, email, and phone number
- The name of my doctor and the clinic where I was treated

By providing my email address below, I am agreeing that protected health information including diagnosis and treatment can be freely shared via email between myself and my clinician at Rhythm of Health, Inc. While usually considered safe, email is not the most secure method of sharing health information:

_____ I authorize the disclosure of health information with my clinician via the following email addresses:
Initials

_____ _____
Email address Alternate email address

This authorization will remain valid for ten (10) years from the date of signature. You may revoke this authorization at any time by writing to Rhythm of Health, Inc. In this case, every effort will be made to discontinue future communications.

_____ _____ _____
Signature (patient or authorized party) Print Name Date