Acknowledgement of Receipt of The Privacy Practices

The privacy practice is/was provided so that I can make an informed decision whether to allow release of the information.

I understand that I do not have to sign this authorization in order to receive treatment from Consiglio Wellness Center. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at:

Consiglio Wellness Center
1501 NW Jefferson St
Blue Springs, MO 64015-7242

Signed by: ____ ______________________________
Signature of Patient or Legal Guardian Relationship to Patient

____ ______________________________
Print Patient's Name Date

____
Print Name of Patient's Legal Guardian (if applicable)

I authorize the staff at Consiglio Wellness Center to release health information to the following individual(s) or medical practice(s):

____
Name Relationship

____
Medical Practice Name/Provider Name Fax Number