HIPAA NOTICE OF PRIVACY PRACTICES

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 in the following instances:

- To conduct, plan, and direct treatment and follow-up among the multiple healthcare providers who may be involved in my treatment directly and indirectly.
- To conduct normal healthcare operations such as quality assessments and physician certifications.
- Obtain payment from third-party payers.
- When issued a proper court order.
- To notify authorities if there may be danger to myself or others, when abuse of a child or vulnerable adult is involved, when a pregnancy may be at risk because of chemical use/abuse, when I have altered a prescription of a controlled substance, or when federal or state law requires it.

I have been informed by you that your Notice of Privacy Practices contains a more complete description of the uses and disclosure of my health information. I have been given the right to review it prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy.

Midwest Wellness Institute
4308 S Arway Dr
Sioux Falls, SD 57106

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, to the extent that you have taken action relying on this consent.

______________________________	______________________________
Printed Name	Signature
______________________________	______________________________
Parent/Guardian, if required	Relationship
______________________________	
Date	