ALTERNATIVE HEALTHCARE SOLUTIONS
PATIENT CONFIDENTIALITY OF INFORMATION CONSENT.

Alternative HealthCare Solutions is required by law to be compliant with all **HIPPA** regulations governing the use and handling of your private medical information. We want you to know that we will use or disclose your personal medical information **only as it is required for;**

- **Carrying out treatment,**
- **Obtaining payment,**
- **Evaluation the quality of our care,**
- **Administrative operations related to treatment or payment,**
- **Public health purposes,**
- **For emergencies.**

Your medical information can and will be sent to third parties such as an your Attorney or the insurance company of a third party, Physicians, case managers or other health professionals at your request **if and only if you first sign a medical release form or we receive a signed medical release form.**

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccuracies or incomplete information.

I understand that I retain the right to request to revoke this consent by notifying AHCS in writing at any time. We will consider each of these requests on a case by case basis but are under no legal obligation to comply with your request.

I have read the above statement and I hereby consent to the use and disclosure of my personal heath / medical information for the purposes as noted above.

_____
Patient Name

_____
Signature

_____
Date