HIPAA: CONSUMER CONSENT AND PRIVACY NOTICE ACKNOWLEGEMENT FORM

I understand that, under the Health Insurance Portability and Accountability Act of 1996 or HIPAA, I have certain rights to privacy regarding my protected health information maintained by *Visions Soulutions Inc*. understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have been informed by you of your NOTICE OF PRIVACY PRACTICES containing more complete description of the uses and disclosure of my health information. I have been given the right to review such NOTICE OF PRIVACY PRACTICES prior to signing this consent. I understand that Visions Soulutions 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 listed above to obtain a current copy of the NOTICE OF PRIVACY PRACTICES.

I also understand that, if I need more information or have questions later, I may contact this agency's representative at the number listed on the NOTICE OF PRIVACY PRACTICES.

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 health care 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, except to the extent that you have taken action relying on this consent.

Consumer's Signature: _____

Parent/Guardian/Personal Representative Signature:

_____

Date: _____ Witness: _____