INTENTIONAL HEALTH CLINIC
1785 NE Sandy Blvd., Suite 290, Portland, OR 97232

HIPAA NOTICE OF PRIVACY PRACTICES AND CONSENT

I hereby give my consent for **Dr. Tatiana Parzynski** to use and disclose **protected health information (PHI**) about me to carry out **treatment, payment,** and **health care operations (TPO),** or as otherwise required by law. The Notice of Privacy Practices provided by Dr. Parzynski describes such uses and disclosures more completely and is part of new patient documents.

- Notice of Privacy Practices details information about the usage and disclosure of my PHI. I have the right to review the Notice of Privacy Practices prior to signing this consent and to receive a printed or electronic copy of the Notice.
- I have the right to request restrictions to the usage and disclosure of my PHI to carry out TPO. I understand that while Dr Parzynski may honor these requests, she is not required by law to do so. If Dr. Parzynski agrees, she is bound by this agreement.
- I have the right to revoke this consent, in writing, at any time, except to the extent that the practice has already made disclosures in reliance upon my prior consent. Revocations will be honored as of the date they are received by Dr. Parzynski at the following address: 1785 NE Sandy Blvd., Suite 290, Portland, OR 97232.
- Dr. Parzynski reserves the right to revise clinic's Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to 1785 NE Sandy Blvd., Suite 290, Portland, OR 97232.
- With this consent, Dr. Parzynski may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.
- With this consent, Dr. Parzynski may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements if they are marked "Personal and Confidential."
- **Communication policy**: e-mail and phone message/text are not secure ways of communication and may be read by a third party. Therefore, the confidentiality of these messages, both sent and returned, cannot be guaranteed. Our preferred secure method of communication is through

Patient Portal which can be accessed through clinic's website www.intentionalhealthclinic.com and/or will be provided to you. If you still choose to use private e-mail and text, please initial _____, in addition to signing this form. Your e-mail address and phone number are used for patient care only and will never be shared with a third party without your consent.

By signing this form, I am consenting to allow Dr. Parzynski to use and disclose my PHI to carry out TPO. If I do not sign this consent, or later revoke it, Dr. Parzynski may decline to provide treatment to me.

_____ _____
Signature of Patient or Legal Guardian Print Patient's Name

_____ _____
Print Name of Legal Guardian, if applicable Date