Consent and Record of Disclosure

I, the undersigned, give consent to Holistic Healthcare Services, Inc., to disclose my treatment or account information for the purposes of treatment or payment to:

Insurance:
Contact Person: ________________
Insurance Co. Name: ________________
Address: ________________
____
____
Phone: ________________
Fax: ________________
Date of Birth: ________________
Claim/ ID #: ________________

Attorney:
Attorney Name: ______________
Practice Name: ______________
Address: ______________
____
____
Phone: ______________
Fax: ______________

Physician:
Name: ________________
Address: ________________
____
____
Phone: ________________

Other: ________________
Name: ________________
Address: ________________
____
____
Phone: ________________

You have a right to restrict which information we release. If you wish to restrict the information released, please describe in writing below. (For example: "I do not consent for information about drug abuse, alcoholism, or HIV testing to be released." Or "The specific information I wish to have released is: _____")

____
____
____

You have a right to withdraw this consent at any time. Such notification must be sent in writing to the Office Manager at the following address:

Office Manager
Holistic Healthcare Services
21 Everett Ave
Belchertown MA 01007

I authorize release of information regarding my treatment to all my insurance companies. I authorize my medical provider to act as my agent in helping me obtain payment from my insurance company. I authorize payment direct to my doctor. I permit a copy of this form to be used in place of the original for all insurance billing.

____________________ ________________________ ____________
Patient Signature Print name Date

Further details of our offices' Privacy Policy are available in written form upon request.