Maranatha Natural Living, LLC

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**Consent to Use Protected Health Information**

**For Treatment, Payment and Health Care Operations**

I consent to allow Maranatha Natural Living, LLC to use or disclose my protected health information for treatment, payment and health care operations.

1. Treatment means the provision, coordination, or management of health care and related services by one or more health care providers
2. Payment means the activities undertaken by a health care provider or business associate or health care plan to obtain or provide reimbursement for the provision of health care, including the right to call the patient, leave messages on the answering machines and/or voicemail.
3. Health care operations means conducting quality assessment and improvement activities, reviewing the competence and qualifications of health care professionals, underwriting , premium rating, and other activities related to health insurance contracts, medical reviews, legal services, auditing functions, and business management and general administrative activities of Maranatha Natural Living, LLC.

I consent to allow Maranatha Natural Living, LLC to disclose my protected health information for treatment activities of another health care provider.

I consent to allow Maranatha Natural Living, LLC to disclose my protected health information to another covered entity or to another health care provider for the payment activities of the entity that receives the information.

I consent to allow Maranatha Natural Living, LLC to disclose personal protected health information to another covered entity for health care operations activities, provided that Maranatha Natural Living, LLC and the other covered entity has or had a relationship with the below named patient. The disclosure must be for treatment, payment or health care operations or for the purpose if health care fraud and abuse detection or compliance.

Receipt of Privacy Practices for Maranatha Natural Living, LLC

Name of patient (Please print)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Person Authorizing Consent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_