Consent to Use and Disclose Health Information

1. Permission to Use and Disclose My Health Information. By signing this form, I give Maleigha Watts, ND permission to use and/or disclose my health information to carry out recommendations, payment or health care operations.

2. Right to Refuse. I have the right not to sign this consent. If I refuse to sign this consent, Maleigha Watts, ND will not provide me with recommendations until I consent. However, treatment required by law, such as emergency care, can be provided to me whether or not I sign this consent.

3. Right to Review Notice of Privacy Practices. Maleigha Watts, ND has provided me with a copy of their Notice of Privacy Practices which describes how Maleigha Watts, ND may use and disclose my health information. I have the right to review this Notice before signing this consent.

4. Changes to the Privacy Notice. Maleigha Watts, ND may change the Notice of Privacy Practices as needed. I may obtain a current copy of the Notice of Privacy Practices by contacting going to http://www.toledonaturopathic.com

5. Right to Request Restrictions on Use/Disclosure. I have the right to request that Maleigha Watts, ND restrict how he/she uses and/or discloses my protected health information for the purpose of providing recommendations, obtaining payment for services, and/or conducting health care operations. Maleigha Watts, ND is not required to agree to any restriction I request. If she does decide to agree to my request, he/she must restrict their use and/or disclosure of my health information the way I asked. Because of the number, complexity, and nature of the services they deliver, Maleigha Watts, ND will rarely agree to requests to restrict uses and disclosures of my health information for the purposes of recommendations, payment, and healthcare operations. Maleigha Watts, ND will notify me of his decision to accept or decline my restrictions.

6. Right to Withdraw Consent. I have the right to withdraw this consent at any time. I must do this in writing. If I want to withdraw this consent, I can contact Maleigha Watts at info@tolednaturopathic.com. Note that my withdrawal of this consent will not be effective for uses and/or disclosures that have already been made based on my prior consent. If I withdraw this consent, then Maleigha Watts, ND, by law, is unable to provide to me further recommendations or follow-up, other than required emergency services.

7. Effective Period. This consent is good unless and until I withdraw it in writing.

8. References to "I" or "me". References to "I" or "me" in this Consent include the individual for whom the signing party is authorized to sign. If I am signing this consent on behalf of another person, it is because I am the legal guardian, parent, or agent under an active Power of Attorney for Health Care, and am legally authorized to sign this Consent on behalf of the individual.

Patient Signature:_____

Date:_____