IDEAL BODY CENTER

NOTICE OF PRIVACY PRACTICES

Dieter Information Release Agreement

I understand that **Ideal Body Center** will use and disclose health information about me.
I understand that my health information may include information both created and received by the above clinic, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, test results, diagnoses, examinations, treatments, procedures, prescriptions, and similar types of health information.

I understand that this clinic may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment;
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- Perform various office, administrative, and business functions that support my physician's efforts to provide me with care.

I also understand that I have the right to receive and review a written description of how this clinic will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information practices followed by the employees, staff, and other office personnel of this clinic, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of this clinic's Notice of Privacy Practices in effect will be posted in the waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that this clinic is not required by law to agree to such requests.

This release of information will remain in effect until terminated by me in writing. By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

Name_____

Date of Birth_____

My Primary Care Physician _____

Phone Number_____

Messages may be left on:

[ ] My home number _____

[ ] My cell number_____

[ ] Other _____

The best time to reach me _____

_____ _____

Participant Date