

**Dr. Dianna Henson**  
Naturopathic Physician

**Consent for Purposes of Treatment, Payment and Health Care Operations**

I consent to the use or disclosure of my protected health information, by **Dr. Dianna Henson**, for the purpose of diagnosis or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **Dr. Dianna Henson**.

I understand that diagnosis or treatment of me, by **Dr. Henson**, may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. **Dr. Henson** is not required to agree to the restrictions that I may request. However, if **Dr. Henson** agrees to a restriction that I request, the restriction is binding on **Dr. Henson**.

I have the right to revoke this consent, in writing, at any time, except to the extent that **Dr. Henson** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review **Dr. Henson's** Notice of Privacy Practices prior to signing this document.

**Dr. Henson's** Notice of Privacy Practices has been provided to me.

The Notice of Privacy Practices for Dr. Dianna Henson is also provided at **2305-A Pacific Avenue, Forest Grove, Oregon**.

This Notice of Privacy Practices also describes my rights and the duties of **Dr. Henson** with respect to my protected health information.

**Dr. Henson** reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised notice of privacy practices by calling the office of **Dr. Henson** and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

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Signature of Patient or Personal Representative

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Name of Patient or Personal Representative

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Date

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Description of Personal Representative's Authority