



# NURSES TOUCH

## Home Health Care Provider, Inc.

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### CONSENT

I, the undersigned, consent to the use of disclosure of protected health information about me for treatment, payment and health care operations.

**Nurses Touch Home Health Provider, Inc.'s** practices with respect to the uses and disclosures of protected health information were discussed with me. For a more complete description of such uses and disclosures, I was provided a copy of **Nurses Touch Home Health Provider's** Notice of Privacy Practices.

I also have been informed that:

- I have the right to review **Nurses Touch Home Health Provider's** Notice of Privacy Practices.
  - I have the right to request restrictions on uses or disclosures of my health information for treatment, payment, and health care operations purposes. **Nurses Touch Home Health Provider** is not required to agree to requested restrictions but is bound by any restriction to which it agrees.
  - I have the right to revoke this consent in writing, except to the extent that **Nurses Touch Home Health Provider** has already taken action in reliance on the consent.
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