HUMMINGBIRD HEALTH & WELLNESS
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Consent for Use and Disclosure of Protected Health Information (PHI)

Ohio HIPAA & State Law–Compliant Authorization

I hereby give my consent for Mente Sana, LLC DBA Hummingbird Health & Wellness ("the Practice") to use and disclose my Protected Health Information (PHI) as necessary to carry out **treatment, payment, and healthcare operations (TPO)** in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and applicable **Ohio Revised Code (ORC)** provisions, including protections for mental health information (ORC §5122.31), HIV-related information (ORC §3701.243), and substance use disorder records (42 CFR Part 2, if applicable).

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1. Consent for Use and Disclosure of PHI

By signing this form, I authorize the Practice to use and disclose my PHI for purposes including, but not limited to:

- **Treatment:** coordination of care, consultations, referrals.
- **Payment:** billing, insurance claims processing.
- **Healthcare Operations:** quality improvement, administrative tasks, training.

I understand that certain types of information—such as psychotherapy notes, substance use disorder treatment information protected by **42 CFR Part 2**, HIV-related information, and specific mental health records—require **additional written consent** before disclosure unless otherwise permitted under Ohio law.

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2. Communication Authorization

With this consent, the Practice may contact me for purposes related to TPO using the following methods:

- **Telephone:** The Practice may call my home, mobile phone, or alternative number and may leave voicemail messages related to scheduling, insurance matters, or my clinical care.

- **Email:** The Practice may email me regarding scheduling, billing, or clinical information. I acknowledge that email may not be a fully secure method of communication.

- **Mail:** The Practice may send mail to my home or alternative address as needed for TPO. Items containing PHI will be marked **"Personal and Confidential."**

I may request restrictions on how the Practice communicates with me, as permitted under HIPAA, and the Practice will accommodate reasonable requests when possible.

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3. Rights Regarding Revocation

I understand that:

- I may **revoke this consent at any time**, in writing, except to the extent that the Practice has already acted in reliance on this authorization.

- Revocation must be submitted to the Practice's Privacy Officer or designated staff.

- My refusal to sign this consent, or later revocation of it, **may limit the Practice's ability to provide treatment**, as permitted under HIPAA. However, the Practice cannot condition treatment on consent for uses/disclosures that are not required for TPO.

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4. Patient Acknowledgment

By signing below, I acknowledge that:

- I have received or been offered a copy of the Practice's **Notice of Privacy Practices (NPP)**.

- I understand that information disclosed by the Practice may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA, except for information covered under **42 CFR Part 2**.

- I understand my rights under HIPAA and Ohio law.

For more information, please visit:
https://www.hhs.gov/hipaa/for-individuals/notice-privacy-practices/index.html

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Patient Name (Please Print)

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Patient Signature **Date**

If signed by a legal representative:

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Name (Please Print)

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Relationship to Patient

This consent complies with **45 CFR §164.506**, **45 CFR §164.510**, **45 CFR §164.520**, and relevant **Ohio Revised Code** requirements for the use and disclosure of mental health and other protected health information.
