

**HIPAA Notice of Privacy Practices and Consent  
Naturopathic Medicine**

I hereby consent to the use and disclosure of my protected health information by my healthcare provider practicing out of Symmetry Health, for the purposes of treatment, payment and healthcare operations, or as otherwise required by law. Symmetry Health has posted their Notice of Privacy Practices which provides more detailed information about the usage and disclosure of my protected health information. I have a right to review the Notice prior to signing this consent and to receive a printed copy of the Notice.

I have the right to request restrictions to the usage and disclosure of my protected health information. I have the right to request an alternative to the standard method of communication of my protected health information. I have the right to revoke this consent, in writing, at any time. Revocations will be honored as of the date they are received by Symmetry Health at the following address:

4432 Ingraham Street, San Diego CA 92109

I understand that while Symmetry Health may honor these requests, they are not required by law to do so. I am aware that Symmetry Health reserves the right to change the terms of their Notice of Privacy Practices and to make new notice of Privacy Practices provisions effective for all protected health information that they maintain. In the event of amendments, Symmetry Health will make available a revised Notice of Privacy Practice for my review.

I have fully read and understand the above agreements and authorizations.

\_\_\_\_\_  
Signature (Patient 18 years or older)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent, Guardian, Responsible Party

\_\_\_\_\_  
Date