LanteRN Health Consulting, LLC
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT CONTACT INFORMATION

Name:_____ Date of Birth:_____

Address:_____

Telephone:_____ E-mail:_____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to LanteRN Health Consulting, LLC ("LHC") use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations (the "Consent") by LHC.

Notice of Privacy Practices: You have the right to read LHC's Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice of Privacy Practices provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. LHC may leave voicemails and send text messages, email or mail to the contact information provided above regarding my appointments, treatment or other protected health information related to my care with LCN. _____ [initial]

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed below. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Kelli Hansen
1310 Larch St
Sandpoint, ID. 83864

SIGNATURE

I,_____, have had full opportunity to read and consider the contents of this Consent and LHC Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to LHC's use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature:_____ Date:_____

If this Consent is signed by a personal representative, parent or guardian on behalf of the patient, complete the following:

Personal Representative/Parent/Guardian Name:_____

Relation to Patient: _____

Signature:_____

Date:_____