ALPHA-LINKS INC
HIPPA FORM

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.

- Obtained payment from designated third-party payers

- Conduct normal health care operations such as quality assessments or evaluations and physician certifications

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information (available in print form upon request). I have reviewed and studied the notice of privacy practices prior to signing this consent. I understand that this organization has the right to change its notice of privacy practices from time to time, and that I may contact this organization at any time at the address above to obtain a current copy of the notices of privacy practices. For questions and concerns, please contact our policy and compliance officer at 202-830-5965.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand the organization is not required to agree to my request restrictions, but if the organization does agree, then it is abounded to abide by such restrictions.

I understand that I can revoke this consent in writing at any time, except to the extent that the organization has acted relying on this consent.