Patient Health Information Consent Form
For Dr. Connie's Chiropractic Center

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we begin any health care operations (treatment) we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI, we encourage you to ask for the longer version.

Would you like to receive the longer version? ___ Yes ___ No

1. You, the patient or parent, understands and agrees to allow this chiropractic office to use your Patient Health Information (PHI) for the purpose of treatment, payment, health care operations and coordination of care. As an example, the patient or parent agrees to allow this chiropractic office to submit a requested PHI to the Health Insurance Company or companies provided to us by you for the purpose of payment or reimbursement.
2. You, the patient or parent, has the right to examine and obtain a copy of his or her own health records at any time and request corrections. You, the patient or parent may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's or parent's written consent need only be obtained once for all subsequent care given the patient in this office
4. You, the patient or parent may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written reque4st to revoke consent, but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known to this office, to assure that your records are not readily available to those who do not need access to them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these polices and procedures.
7. If you, the patient or parent refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

_____	_____	_____
Name of Patient/Child (Print Please)	Patient/Parent Signature	Date Signed

Dated 4/13/2003