

# CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION



## **Our Privacy Pledge**

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to disclose your health information within our practice for quality control or other operational purposes (testimonials, possible newspaper quotes, etc.)
- We may use your personal information for use in sending you postcards, holiday cards, birthday cards, administrative letters, and other miscellaneous cards.

If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail.

## **Your right to limit uses or disclosures**

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the agreement is binding on us.

## **Your right to revoke your authorizations**

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we received your request to revoke your authorizations. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Authorized Provider Representative

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

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**APPOINTMENT REMINDERS**

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine, voice mail or with the available person. By signing this form, you are giving us authorization to contact you with the reminders and information.

You have the right to refuse to give us this authorization. If you do not give us authorization it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

This notice is effective as of \_\_\_\_\_ . This authorization will expire seven years after the date on which you last received services from us.

\_\_\_\_\_  
Patient name printed

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient name signature

\_\_\_\_\_  
Authorized Provider Representative

\_\_\_\_\_  
Personal Representative Printed

\_\_\_\_\_  
Personal Representative Signature

\_\_\_\_\_  
Description of personal representative's authority to act for the patient