

Consent for Use and Disclosure of Health Information

By signing this form, I give Clemenson Chiropractic, consent to use and/or disclose my protected health information (PHI) to carry out treatment, payment or health care operations.

I have the right not to sign this consent. If I refuse to sign this consent, Clemenson Chiropractic may refuse to provide me with treatment until I consent.

Clemenson Chiropractic has offered to provide me with a copy of its Notice of Privacy Practices which describes how this clinic may use and disclose my health information. I have the right to review this notice before signing this consent.

I acknowledge that a copy of this clinic's Notice of Privacy Practice's has been made available to me. I also understand that a copy of this Notice is available upon request.

Clemenson Chiropractic may change the Notice of Privacy Practices as needed. I may obtain a current copy of the Notice of Privacy Practices by contacting our office.

I have the right to withdraw this consent at any time. I must do this in writing. Note that my withdrawal of this consent will not be effective for uses and/or disclosures that have already been made based on my prior consent. If I withdraw this consent, then Clemenson Chiropractic, by law, is unable to provide to me further treatment or follow-up.

This consent is good unless I withdraw it in writing.

Printed Name

Signature of Patient or Legal Representative

Date of consent

Rev 01/2015