

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 use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (§ 164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

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 restriction is binding on us.

Your right to revoke your authorization

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 receive your request to revoke your authorization. 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

INFORMED CONSENT

After reviewing your health history, the Doctor will examine you and may require other diagnostic tests, such as X-rays, MRI or Lab tests, to make an accurate diagnosis and treatment plan. The Doctor will select a treatment plan which best suits your needs. You will be informed of all alternative treatments available to you. Occasionally the plan may have to be altered during treatment, due to unexpected changes. We encourage you to ask the Doctor any questions you may have so you fully understand your condition.

At this time, we would like to inform you of the risks that may occur from Chiropractic treatment. They are as follows: muscle soreness and irritation, headache, pain, muscle spasm and stiffness. In rare instances, dizziness and/or nausea may occur.

If there is anything you do not understand, please discuss it with the Doctor before signing the statement below.

I certify the information I provided for the health history is true and factual to the best of my knowledge. I understand the office policy and the risks of chiropractic treatment, which were supplied in the statement above. Any additional information which may occur will be supplied to you. I hereby consent to chiropractic treatment.

(Patient's Signature)

(Date)

The patient is unable to consent because _____
(i.e. underage, mentally handicapped, etc.) I, therefore, consent for the patient.

(Signature)

(Date)

Relationship to patient: _____