Patient Health Consent Form

Your rights concerning your Patient Health Information (PHI) are important to us. Please review the privacy policies carefully. You can obtain a copy of the HIPPA NOTICE at the front desk if you require additional information.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, and healthcare operations. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient 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 written consent need only be obtained one time for all subsequent care given the patient after the request has been presented.
4. The patient 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 after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient privacy and a privacy official had been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and healthcare operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Printed Name of Patient Date

Our office is unable to discuss your Patient Health Information with any individual including spouses and relatives. If you would like to give authorization for your PHI to be discussed with a specific individual, list their name(s) below and provide your signature to give our office authorization.

_____ _____

_____ _____

Signature of Patient Date