McIlroy Chiropractic Arts

Patient Consent and Acknowledgement of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services, McIlroy Chiropractic Arts creates and maintains health records and other information describing among other things, my health history, symptoms, examinations and test results, diagnoses, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used and disclosed to carry out treatment, payment or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information (PHI) about me for the purposes of treatment, payment and health care operations, I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent. This consent is given freely with the understanding that:

- Any and all records, whether written or oral or in an electronic format are confidential and can not be disclosed for reasons outside of treatment, payment or healthcare operations without my prior written authorization, except as otherwise provided by law.
- A photocopy or fax of this consent is as valid as this original.
- I have the right to request that the use of my PHI which is used for the purposes of treatment, payment or healthcare operation be restricted. I also understand that the practice and I must; agree to any restriction in writing that I request and agree to terminate any restrictions in writing on the use and disclosure of my PHI which have been previously agreed upon.

_____ _____

Patients Name (printed) Date

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Patients Signature (Guardian if a minor)

_____ _____

Witness (optional) Date