## Consent for Use or Disclosure of Health Information

Here at Johnson Family Chiropractic, 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 use or disclose your health care 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.
- We may have to use or 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 Disclosure

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 u 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 and mailed to us at our office address. We will not be able to honor your request if we have already released you health information before we received 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.

## Appointment Reminders

Your chiropractor and members of Johnson Family Chiropractic may need to use your name, address, phone number, an your clinical records to contact you with appointment reminders, information about treatment alternatives, or other healt related information that may be of interest to you. If this contact is made by phone and you are not home, a message will be left on your answering machine. By signing this form, you are giving us authorization to market the following products and or services to you. _____

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules 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.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information abou treatment alternatives, or other health related information at any time (§164.524).

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

I have read your consent policy and agree to its terms. I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have read and agree to the above stated authorizations.

_____ _____ _____

Patient Name **PRINTED** Patient **SIGNATURE** Date

_____ _____

Personal Representative **PRINTED** Personal Representative **SIGNATURE**

_____ _____

Description of Personal Representative's Authority to act for the Patient Authorized Provider Representative Signature