



CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION (HIPPA)

**This notice describes how chiropractic and medical information about you may be used and disclosed, your rights as a patient, and ways for you to get additional information on our policies.**

Our clinic has always been very protective and respectful of your personal information. Under new federal regulations (the HIPPA Privacy Act), we have adopted additional guidelines to ensure the proper use, confidentiality, and disclosure of health information.

We may disclose or release your health information:

- For treatment purposes to another healthcare provider or clinic if we were for you, or two providers or staff within our clinic that are taking part in your care.
- For billing and collection purposes, we may release records of your healthcare and information that you provided to your insurance carrier for other financially responsible parties.
- For operational purposes within our clinic for quality control, office administration, record keeping, and staff or training.

Specifically, you authorize the release of any information pertinent to your case to any insurance company, adjuster, or attorney involved in this case for the purpose of obtaining payment on your health claims.

We may also use your personal health information to contact you regarding your appointments, to send you information about our clinic our office events, or to share treatment options. We will not disclose information about you to anyone outside our office without your written approval.

You have the right to inspect or obtain a copy of the information we will use for these purposes. You have the right to amend your records at this office. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care. Request to inspect, copy or amend your health related information should be provided to the Front Desk in writing.

We normally provide information about your health to you in person at the time you receive care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or if you would like the information in a different form, please advise us in writing as to your preferences.

Information that we use or disclose based on this privacy notice maybe subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, privacy practices or any aspect of our privacy activities you should direct your complaint in writing to the Clinic Director.

If you would like further information about our privacy policies and practices please see the notice of privacy practices binder at the reception or ask for a copy at the front desk.

Print Name: \_\_\_\_\_

Sign \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

(If you are under 18 years of age, we need a parent or guardian signature authorizing us to treat you.)

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_