

Hassig Family Chiropractic

Patient Consent for use and/or disclosure of protected health information to carry out treatment, payment and healthcare operations.

_____, hereby states that by signing this Consent, I acknowledge and agree as follows:

1. Hassig Family Chiropractic's Privacy Notice has been provided to me prior to me signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for Hassig Family Chiropractic to provide treatment to me, and also necessary for Hassig Family Chiropractic to obtain payment for that treatment and to carry out health care operations. Hassig Family Chiropractic explained to me that the Privacy Notice will be available to me in the future at my request. Hassig Family Chiropractic has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. Hassig Family Chiropractic reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that will be used by Hassig Family Chiropractic: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.
4. Hassig Family Chiropractic may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for Hassig Family Chiropractic to treat me and obtain payment for the treatment, and as necessary for Hassig Family Chiropractic to conduct its specific health care operations.
5. I understand that I have a right to request the Hassig Family Chiropractic restrict how my PHI is used and/or disclosed to carry out treatment, payment, and/or health care operations. However, Hassig Family Chiropractic is not required to agree to any restrictions that I have requested. If Hassig Family Chiropractic agrees to a requested restriction, then the restriction is binding on Hassig Family Chiropractic.
6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that Hassig Family Chiropractic has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time, Hassig Family Chiropractic has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then Hassig Family Chiropractic will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Name of Individual (Printed)

Signature of Individual

Signature of Legal Representative
(e.g. Attorney-In-Fact, Guardian, Parent if minor)

Relationship

Date signed ____/____/____

Witness: _____