

**New Beginnings Chiropractic: Use or Disclosure of Protected Health
Information Acknowledgement and Consent**

Your Privacy: The federal laws that protect your protected health information (HIPPA) do not provide you with complete privacy. HIPPA allows your health care provider to use or disclose your protected health care information without further authorizing or consent from you in a number of circumstances, such as:

- In the course of providing you treatment;
- In the event of a referral to another health care provider as necessary for the diagnosis, assessment or treatment of your health condition;
- For insurance and billing purposes;
- In limited and unusual circumstances related to public health matters and research.

Our Privacy Policy: We are very concerned with protecting your privacy, and always will respect the privacy of your health information. Along with this consent form, you will be given a copy of our privacy policy upon request, in detail. You have the right to review our privacy policy before you sign this consent form. We reserve the right to change our privacy policy. If we make a change, we will notify you in writing when you come in for treatment or by mail.

Your right to limit uses or disclosures: You have the right to restrict our ability to use or disclose your protected health information with specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, you must inform us in writing.

Your chiropractor and members of this practice staff may need to use your name, address, phone number, email address and your clinical records to contact you with appointment reminders and information about treatment alternatives. If this contact is made by phone and you are not available, a message will be left on your answering machine or voicemail, or with the person answering the phone. By signing this form, you are consenting for us to contact you with these reminders and information and to leave messages on your answering machine or with individuals at your home or place of employment.

Our office also infrequently sends out other information via mail or email. These include, but are not limited to, birthday cards, information on changes at the clinic which may affect you, and newsletters, and are meant to ensure the best care possible.

Your right to authorize us to disclose your protected health information: You have the right to authorize us to disclose your protected health information to specific individuals, companies or organizations. If you would like to make an authorization, we will ask you to complete an authorization form.

Your right to revoke any limitation, authorization or consent: You have the right to revoke any limitation or authorization to use or disclose your protected health information at any time. Your revocation must be in writing. If you refuse to give us an authorization or consent or revoke any authorization or consent in the future, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

I ACKNOWLEDGE receipt of the PRIVACY POLICY and CONSENT to my personal health information being used in the manner described above. I am also acknowledging that I have received a copy of this consent.

Patient Name Printed

Date

Patient (or Personal Representative) Signature

Authorized Provider Representative