Consent for Use or Disclosure of Health Information

Our Privacy Pledge

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 disclose your health 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 condition.
- We may have to 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.

I have read your consent policy and agree to its terms.

_____ _____

Signature Date

Marketing Authorization

From time to time our practice will mail out marketing materials such as a bi- monthly newsletter, special promotions such as "Patient Appreciation Day", birthday cards, reminder notes or thank you letters. We may use your name in our newsletter. We may use your name in our patient testimonial book in our lobby area. We are specifically requesting authorization to use your name in our marketing and advertising efforts, we will not give out your information to outside marketing facilities.

You have the right to refuse to give us this authorization. This will mean that you will not receive special promotion notifications, birthday cards, etc. which may offer free services. If you do not give us permission, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

I authorize you to use or disclose my health information in the manner described above.

_____ _____

Patient signature Date

Appointment Reminders and Health Care Information Authorization

Your chiropractor and members of the staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health 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 contact you with these reminders and information.

I authorize you to use or disclose my health information in the manner described above.

_____ _____

Patient signature Date

You may revoke your authorization 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 revocation request if we have already released your information before we receive your request to revoke your authorization.