

*HEALTH INFORMATION DISCLOSURE AND CONSENT*

**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.

1. 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.

2. We may have to disclose your health information and billing records to another party if they are potentially responsible for payment of your services.

3. We may need to use your health information within our practice for quality control or other operational purposes.

We may 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 in 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 revoke your authorization**

You may revoke your consent to us at any time: however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have the right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I also acknowledge that I have been given the option to receive a copy of this notice.

I have also read the marketing and fund raising provisions on the opposite of this page and by indication of my initials, have consented to those activities.

Printed name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Authorized Provide Representative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Marketing*

On a quarterly basis, our practice sends informational newsletters to make you aware of products of services that occasionally we may include information or service recent health research, health diet, and exercise ideas on a product you may have an interest in purchasing. We may need to use your health information including your name, address, phone number, and your clinical records for the purpose of sending our newsletter, marketing products, and/or services to you. We are specifically requesting authorization to market chiropractic services, nutritional products and rehabilitative products to you.

You have the right to refuse to give us authorization to contact you for marketing purposes. 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 market products and/or services to you at any time. Our practice and staff will receive direct or indirect remuneration from our marketing activities.

Initials\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Fund Raising*

From time to time, our practice raises donations (canned food items and money) for local charities and/or chiropractic causes. We may need to use your health information including your name, address, phone number, and your clinical records to contact you to request your assistance with these fund raising efforts. We are specifically requesting authorization to solicit these donations from you for our annual “Great-In-8k Run” .

You have the right to refuse to give us authorization to contact you for marketing purposes. 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 market products and/or services to you at any time. Our practice and staff may receive direct or indirect remuneration from our fund raising activities.

Initials\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_