PERFORMANCE
Health Chiropractic

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CONSENT FOR USE OF 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 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.
- We may need to use your personal information to remind you of appointment, send you a birthday card, send you a thank you for referrals, acknowledge your referral on an office referral board, send you a welcome to the office informational letter, invite you to participate in a patient appreciation day or patient orientation/spinal care class, send you an office newsletter, use your photo on a patient appreciation board and/or personal testimonial you may write, have you sign your name on a sign in a sheet at the counter, or send you promotional and billing information through the mail.

We 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. We reserve the right to change our privacy practices as described in that notice. If we make a change to 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 practices notice.

YOUR RIGHT TO LIMIT USE OR DISCLOSURES

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restriction on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree to your restriction(s) the restriction(s) will be binding upon us.

YOUR RIGHT TO REVOKE YOUR AUTHORIZATION

You make revoke your consent to our privacy pledge/policy 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 information before we received your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a 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 am also acknowledging that I have received a copy of this notice.

_____

(Print Name)

_____

(Signature)