

# CHIROPRACTIC CARE CENTER

## PATIENT CONSENT FOR PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I \_\_\_\_\_, hereby state that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice has explained to me that the Privacy Notice would be available to me in the future at my request. The Practice had further explained my rights 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 signing this Consent.
2. The practice 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 the Practice: 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. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
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 the Practice has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time, the Practice 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 the Practice may not treat me.

### ADDITIONAL PROVISIONS

- **PRODUCTS AND SERVICES:** From time to time our practice would like to make you aware of products or services that you may have an interest in purchasing. This marketing could be done by our internal staff or by outside marketing organization. You're Chiropractor and members of the practice staff may need to use your health information including your name, address, phone number and clinical records for the purpose of marketing products and services from Chiropractic Care Center to you. The following are examples: Patient Newsletters, special offers for you, your family and friends for treatment, orthopedic pillows, other therapy devices, postcards for free information reports.

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

---

Name of Patient (printed)

---

Signature of Patient

---

Date Signed