

COMMUNITY CHIROPRACTIC
8110 Hwy 51 North, Suite # 2
Millington, TN 38053

901-872-0760(Phone)
901-872-3120(Fax)

Consent to use PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Community Chiropractic or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. **If you would like a full copy of the Notice of Privacy Policy, please initial here.** _____

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Notice of Treatment in Open or Common Areas

Our office staff may use your name in open/common treatment areas in your presence when other patients may be present, also, & able to hear your information. We would only discuss your treatment plan and options in their presence.

May our office leave a message on an answering machine, voicemail, or with another family member concerning upcoming or missed appointments? _____ **Yes** _____ **No (Please Initial)**

By my signature below I give my permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature

Date

Print Patient's Full Name

Time

Witness Signature

Date