O'Hara Family Chiropractic

PATIENT CONSENT

FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

________________, hereby states that by signing this consent, I acknowledge and agree as follows:

1. The practice's Privacy Notice was provided to me before I signed 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 for the practice to obtain payment for treatment and carry out its health care operations. The practice explained to me that the Privacy Notice will be available to me in the future at my request. The practice has further explained my right 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 my signing this consent.

2. The practice reserves the right to change its privacy practices described in its Privacy Notice in accordance with applicable laws.

3. I understand and consent to the following appointment reminders that the practice will use: 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 who answers 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) 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 healthcare 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 based 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, which shows my consent to the uses and disclosures described above and in the Privacy Notice, then the practice will not treat me.

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

____
Name of individual (printed)

____
Signature of individual

____
Signature of legal representative

____
Relationship
(e.g., Attorney, Guardian, Parent if a minor)

Date signed: ____________________

Witness: ________________________