Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of you Protected Health Information

Your protected Health Information will be used by Bay Oaks Chiropractic (clinic name) or disclosed to others for the purpose of treatment, obtaining payment, or supporting 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. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of You 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 of 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 or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change privacy practice

This office reserves the right to modify the privacy practices outlined in the Notice.

Signature

I have reviewed this consent form and give my permission to this office to use and disclose my health information in accordance with it.

Name of Patient (print)

Signature of Patient Date

Signature of Patient Representative Date

Relationship of Patient Representative

Office Representative Date

Others we may release you PHI to

Please read & sign the attached Privacy Statement. The U.S. GOVT. requires all medical providers to have all patients understand & sign.