

# DAPHNE CHIROPRACTIC CENTER, L.L.C.

## PATIENT HEALTH INFORMATION: PRIVACY NOTICE AND CONSENT FORM (HIPPA)

We want you to know how your Patient Health Information (PHI) is going to be used in this office and about your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow DAPHNE CHIROPRACTIC CENTER, LLC to use my (my child's) Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow DAPHNE CHIROPRACTIC CENTER, LLC to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to obtain a copy and/or examine his or her own health records at any time and to request corrections. The patient may request to know what disclosures have been made and to submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This will not effect the use of those records for the care given prior to the written request to revoke consent but will apply to any care given after the request has been presented.
5. For our patients' security and right to privacy, all staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

I give permission to share my personal health information with my spouse and immediate family.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date