

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal health information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will strive to secure and protect that privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposed of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

- MY SIGNATURE (on back) INDICATES I HAVE RECEIVED THE HIPAA NOTICE OF PRIVACY PRACTICES

PATIENT AUTHORIZATION:

CONTACT REGARDING CHIROPRACTIC CARE, RELATED HEALTH SERVICES AND/OR RELATED HEALTH PRODUCTS

It is our desire for our staff to use your name, address and/or telephone number for the purpose of contacting you to advise you about health related meetings, workshops, and products. The use of this information is intended to make your experience with our office more efficient, productive and to further enhance your access to quality health care. If you choose not to authorize this information your decision will have no adverse effect on your care from Pomeroy Chiropractic or on your relationship with staff.

- MY SIGNATURE (on back) INDICATES MY AUTHORIZATION OF THIS ACTIVITY

