Palmetto State Chiropractic, LLC

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Privacy Pledge To You:

We are very concerned with protecting your privacy. While the Law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information. There are several circumstances where we may have to use or disclose your health information:

- We may have to disclose information to another health care provider or hospital if it is necessary to refer you to them for the diagnosis, assessment or treatment of your health.
- We may have to disclose information and billing records to another party if they are potentially responsible for the payment of your services.
- We may have to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have a right to review that notice before you sign this consent form (164.520). We reserve the right to change our privacy practice as described in that notice. If any changes are made, you will be notified in writing by our office. Please feel free to call us at anytime for a copy of our privacy notices.

Your Right To Limit Uses Or Disclosures:

You have a right to request that we do not disclose your health information to specific individuals, companies or organizations. If you would like to place restrictions of the use or disclosure of your health information, please do so in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding to us.

Your Right To Revoke Authorization:

You may revoke your consent to us at any time; but it must be done in writing. We will not be able to honor your revocation request if we have already released your health information prior to receiving your request to revoke authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

APPOINTMENT REMINDER AND HEALTH CARE INFORMATION AUTHORIZATION

Your Chiropractor and members of our staff at Palmetto State Chiropractic need to use your name, address, phone number, and your records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may interest you. If this contact is made by phone and you are not home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organizations to which your health information is released to or you may revoke your authorization to us at any time. However, your revocation must be done in writing and mailed to our office address. We will not be able to honor any revocation request if we have already released your health information prior to our office receiving your request to revoke authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have the right to your health information if they decide to detest a claim.

Information we use or disclose based on the authorization you're giving may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules. You have the right to refuse to give us this authorization. If you do not give us this authorization, it will not affect the treatment we provide to you or the method we use to obtain reimbursement for your care.

You may inspect or copy the information we use to contact you to provide appointment reminders, information about treatment alternatives or other health related information at any time. (164.524)

- I have read your consent policy and agree to its terms. I am also acknowledging that I have received or been offered a copy of this notice.
- This notice is effective as of the date listed below. This authorization will expire seven years after the date of which you last receive services from us. I authorize you to use or disclose my health information in the manner described above.

✖ Patient Name Printed: ______________________________ Date: ____________________

✖ Patient Signature:______________________________ Employee Witness: ____________________

(Or, ***Personal Representative***: Please describe how personal representative acts as authority for patient)

Palmetto State Chiropractic, LLC
3427 Hwy. 153 Piedmont, SC 29673
Phone (864) 220-5424 Fax (864) 220-5423

PATIENT RECORD OF DISCLOSURES

In general, the HIPPA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of individual's home.

➢ I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone ______________________

☐ Leave message with detailed information at home.

☐ Leave message with call-back # ONLY at home.

☐ Work Telephone ______________________

☐ Leave message with detailed info at work.

☐ Leave message with call-back # ONLY at work.

☐ Written Communication

☐ Mail to my home address

☐ Mail to my work/office address below
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☐ Fax information to ______________________

☐ Other ______________________

✖ Patient Signature:______________________ Date:______________________

FOR OFFICE USE ONLY BELOW

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted with prior consent in an emergency.

RECORD OF DISCLOSURES OF PROTECTED HEALTH INFORMATION

Date	Disclosed to whom/ address or fax number	(1)	Description of disclosure/ purpose of disclosure	By Whom Disclosed	(2)	(3)

(1) Check if the disclosure is ***AUTHORIZED.***
(2) Key: **T** = *treatment records* **P** = *payment information* **O** = *healthcare operations*
(3) Key: **F** = *fax* **P** = *phone* **E** = *email* **M** = *mail* **O** = *other*