Consent for Use or Disclosure of Health Information
Mt Juliet Chiropractic, PC

Our Privacy Pledge

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 in which we may need to use or disclose your health care information.

> We may need to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition. We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services. We may need 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 the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures

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

Your right to revoke your authorization

You may revoke your consent to us at any time: however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your 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.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

______________________________	______________________________
Printed Name	Authorized Provider Representative
______________________________	______________________________
Signature	Date

Appointment Reminders, Newsletter and Health Care Information Authorization

Your chiropractor and members of the practice staff of Mt Juliet Chiropractic, PC, may need to use your name, address, phone number, and clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. We will not sell or share your information with marketing organizations.

May we send a reminder card to your home? Yes ________ No________

May we call your home with appointment reminder, missed appointment? Yes_______ No_______

If you are not at home, a message will be left on your answering machine.

May we leave messages with anyone else in your household? Yes________ No_______

Name/Relationship:____

May we call you at work? Yes_________ No________ #_____________________ Ext#______________

Leave message on voice mail? Yes___________ No__________

Leave message with:____

Would you like to receive our Newsletter via e-mail? Yes _______ No_______

E-Mail Address:____

Our newsletter may contain information on products services you may be interested in purchasing.

Are there any individuals with whom you would like to give us authorization to discuss your health care information, ie, spouse or family member? If so, please name: __________________________________

You have the right to request that we do not disclose your health information to specific individuals, companies or organizations. **If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing.** We are not required to agree to your restrictions. However, if we do agree, the restriction is binding on us. **You may revoke your consent to us at any time; however, your revocation must be in writing** and mailed to us or delivered to a staff member of our office. We will not be able to honor your revocation request if we have already released your information before receipt of your revocation.

Information that we use or disclose based on the authorization you are giving us may be subject to redisclosure by anyone who has access to the reminder or other information and may no longer be protected by federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

I authorize you to use or disclose my health information as described above. I am also acknowledging that I have received a copy of this authorization.

This notice is effective as of April 14, 2003. This authorization will expire seven years after the date on which you last received services from us.

____ Patient name printed

____ Date

____ Patient Signature

____ Authorized Provider Representative

____ Personal representative printed

____ Personal representative signature

____ Personal representative's authority to act for patient