Mt Juliet Chiropractic, PC
2345 N Mt Juliet Rd.
Mount Juliet, Tennessee 37122-3037
PH: 615-758-8978

Consent to use PHI

Acknowledgment for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Mt Juliet Chiropractic, PC or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the 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. I have received a copy of the Notice of Patient Privacy Policy.

_____Patient Initials

Requesting a Restriction on the Use or Disclosure of Your 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 or 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 upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas

Describe and Notify private areas available upon request

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature	Date
Print Patient's Full Name	Time
Witness 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, email address 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.

Would you like either of the following appointment reminders?

Text: Yes_____ No_____ Phone Number:_____

Email: Yes_____ No_____ Email Address:_____

Would you like to receive our newsletter via email? Yes_____ No_____

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

_____

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 also acknowledge that I have received a copy of this authorization.

This notice is effective as of November 22, 2024. This authorization will expire seven years after the date on which you last received services from us.

_____ _____

Patient name printed Date

_____

Patient or Legally Authorized Individual Signature

_____

Legally Authorized Individual Name printed Authority to act for patient

Robin M. Poetta DC _____

Authorized Provider Representative Date