



PATIENT HEALTH INFORMATION CONSENT FORM

Adventure Chiropractic wants you to know how your Patient Health Information (PHI) will be used in this office and your rights concerning those records. Before we will begin any health care operations we 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 more details please request a **HIPPA PRIVACY NOTICE** available at the front desk, before signing this consent.

1. The patient understands and agrees to allow Adventure Chiropractic to use their PHI for the purpose of treatment, payment, healthcare operations and coordination of care. Our office will limit the release of all PHI to the minimum needed for correspondence with other healthcare providers and insurance companies.
2. The patient has the right to examine and obtain a copy of his/her own health records at any time. The patient may request corrections and to know what disclosures have been made and may submit, in writing, any further restrictions on the use of their PHI. However, changes and restrictions made and agreed to by us must be within the scope of State and Federal laws.
3. The patient's written consent need only be obtained one time for all subsequent care given at Adventure Chiropractic.
4. The patient may provide a written request to revoke consent at any time during their care. **Please note:** this request would only apply to records from the date of the request forward, and does not include use of records prior to the request.
5. Adventure Chiropractic may contact you periodically regarding appointments, treatments, products, services, payments or charitable work performed. You have the right to "opt-out" of any marketing of fundraising communications at any time.
6. Adventure Chiropractic enforces the "right to privacy". All our staff is trained in patient record privacy and a privacy official has been designated to ensure those procedures are implemented and adhered to in our office. Your records are not readily available to those who do not need them.
7. The patient has a right to file a formal complaint with our privacy official and with the Secretary of HHS about any possible violations of these policies and procedures, without retaliation by Adventure Chiropractic.
8. Adventure Chiropractic reserves the right to make changes to this notice and make new notice provisions effective for all protected health information that it maintains. If changes are made, you will be provided with the new notice.
9. Refusal to sign this consent may result in our right to refuse care.

I have read and understand how my PATIENT HEALTH INFORMATION (PHI) will be used and agree to the above policies and procedures

Print Name

Signature

____/____/____
Date