DUNNE CHIROPRACTIC

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

____, hereby states that by signing this Consent, I acknowledge and
(Patient Name) agree as follows:

1. The Practice Privacy Notice has been provided to me prior to signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for Dunne Chiropractic to provide treatment and to carry out its health care operations. Dunne Chiropractic has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this consent.
2. Dunne Chiropractic reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that will be used by the Dunne Chiropractic: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering machine c) text messages to the cell phone number I provided) emails to the email address that I provide.
4. I understand that my name may be displayed or utilized in such areas as referral board, sign in sheets, Thank You referrals, facebook, emails, advertisements, etc.
5. Dunne Chiropractic may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for Dunne Chiropractic to conduct its specific health care operations.
6. I understand that I have a right to request that Dunne Chiropractic restrict how my PHI is used and/or disclosed to carry out treatment, payment, and/or health care operations. However, Dunne Chiropractic is not required to agree to any restrictions that I have requested. If Dunne Chiropractic agrees to a requested restriction, then the restriction is binding on Dunne Chiropractic.
7. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that Dunne Chiropractic has the right to refuse to treat me.
8. I understand that if I revoke this consent at any time, Dunne Chiropractic has the right to refuse to treat me.
9. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, than Dunne Chiropractic.

I have read and understand the foregoing notice and all of my questions have been answered to my full satisfaction in a way that I can understand.

______________________________________ ______________________________________
Name of Individual (printed) Signature of Individual

______________________________________ ______________________________________
Signature of Legal Representative (e.g. Guardian, Parent if a minor) Relationship

Date Signed _______/_______/_______ ______________________________________
Witness