Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must 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 to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient Date

Identification of Persons with Authorization of Access to Patient Health Information

Those individuals or parties that could have access to Patient Health Information at Loving Care Family Chiropractic Center include but may not be limited to:
The staff of Loving Care Family Chiropractic Center. This includes:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Necessary health care providers or vendors who may need to be consulted if related to the patient's condition. This includes:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

The minimum categories and or types of Patient Health Information necessary for access by these individuals or parties include but are not limited to:

(Insert Health History Form, Insurance form, etc)

925 Main Street Suite 108
Stone Mountain, GA 30083
678-476-3778 Office
1866.810.3847 Fax

AUTHORIZATION FOR RELEASE/DISCLOSURE OF PROTECTED MEDICAL RECORDS

TO: _____

At the request of the undersigned, you are hereby authorized, requested and directed to disclose protected health information about me as described below for the purpose of evaluation and/or treatment with a Doctor Loving Care Family Chiropractic.

1. The following specific person or class of persons or facility is authorized to make the requested disclosure: any and all medical doctors, hospitals, emergency treatment centers, private health care facilities, chiropractors, physical therapists, or any other persons or facilities who have provided any health related treatment, diagnosing testing, or test analysis on behalf of the undersigned or who maintain any documentation pertaining to the physical and/or mental condition of the undersigned.

2. Loving Care Family Chiropractic may receive disclosure of protected health information about me.

3. The specific information that should be disclosed is: documentation pertaining to the physical and mental condition of the undersigned, including patient history, examination, diagnosis, treatment, prognosis, opinion, x-ray and complete treatment file. I understand that this disclosure may include psychiatric, drug/alcohol, and/or HIV testing results, and/or AIDS related information. You are further authorized, requested and directed to discuss any relevant knowledge you may have related to any of the above-referenced information with the Doctor(s) of Loving Care Family Chiropractic

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

5. I may revoke this authorization by notifying Loving Care Family Chiropractic in writing of my desire to revoke it. However, I understand that any action already taken in reliance of this authorization cannot be reversed, and my revocation will not affect those actions. I understand that any medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign this authorization. This authorization shall remain in effect regardless of the lapse of time, unless revocation is submitted to Loving Care Family Chiropractic in writing as stated above.

6. This authorization and/or request to release information from my protected health information (PHI) is fully understood and is made voluntarily on my part and includes faxing of my PHI to/from Loving Care Family Chiropractic .

Patient's Name: _____ Date: _____

Guardian's Name: _____ For: ☐ Minor ☐ Mental/Physical disable

Patient/Guardian's Signature: _____

Patient's DOB: _____

Patient's SSN _____-_____-_____ Guardian's SSN: SSN _____-_____-_____

Witness's: _____ Date: _____