MADISON UPPER CERVICAL CENTER

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used by this office and your rights concerning those records. Before we 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 PHI, 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 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 provided to us by the patient for the purpose of reimbursement. Be assured that this office will limit the release of all PHI to the minimum needed.
2. This patient has a 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 with 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 affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care 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 chiropractor has the right to refuse to give care.
8. From time to time, we may send you a birthday card or letters from our office or place a reminder phone call. By your signature below, you have given us permission to do so.
9. In order for our office to provide ANY information to your spouse, parent, relative, or other designates, we must have your permission. (This includes appointment schedules, x-rays, receipts, health records, and any other information that pertains to your treatment.) You may indicate your permission by listing names here:

10. Please indicate the name and contact information of your primary care physician for the purpose of care coordination with this chiropractic office.
    PCP Name: _____
    Address/Phone: _____

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

_____ _____

Patient Signature Date