Petry
CHIROPRACTIC & WELLNESS

Consent for Use or Disclosure of Health Information

At Petry Chiropractic and Wellness, we are very concerned with protecting your privacy. The law requires us to give you this disclosure and please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information:

- We may have to disclose your health information to another health care provider or hospital if it is necessary to refer you to them for the diagnosis, assessment or treatment of your condition.
- We may have to disclose your information to another health provider or hospital if it is necessary to request additional information including (but not limited to) previous blood test and/or urinalysis results or treatment history.
- We may have to disclose your information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your information within our practice for quality control and other operational purposes.

We reserve the right to change our privacy practices as needed. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail.

Your right to limit disclosure of information

You have the right to request that we do not disclose your health information to specific individuals, companies or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing.

Your right to revoke your authorization

You may revoke any of your authorizations at any time, however the revocation must be in writing. The revocation will become active the date it is received. If you were required to give an authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Appointment Reminders

The doctors and/or members of the practice staff may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, return any phone calls, or any other information that may be of interest to you. If this contact is made by phone and you are not available, a message will be left on your answering machine or with the person answering the phone. By signing this form, you are giving us authorization to contact you with those reminders or information and to leave messages on your answering machine or with individuals at your home or place of employment.

I have read the consent policy and agree to its terms. I am also acknowledging that I can receive a copy of this form (if I so request one).

Printed Name _____

Signature (Patient or Guardian) _____ Date: _____

Relationship of Guardian to Patient _____

Provider Representative: _____ Date _____