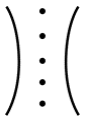

Amory Chiropractic

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 begin any healthcare operations, we must require you to read and sign this consent form stating that you understand and agree with how your record will be used. If you would like to have more information we encourage you to read the NOTICE OF PRIVACY PRACTICES that has been provided to you before signing this consent.

1. The patient understands and agrees to allow Amory Chiropractic to use their Patient Health Information (PHI) for the purposes of treatment, payment, healthcare operation, and coordination of care. As an example, the patient agrees to allow Amory Chiropractic 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, if needed. The patient may request to know what disclosures have been make and submit in writing any further restrictions on use of his or her 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 to 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 given after the request has been presented.
5. For your security and right to privacy, all staff have 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 healthcare operations, our office has the right to refuse care to the patient.

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

Print Name_____

Signature_____ Date_____