Hanson Chiropractic Clinic, P.A., 306 N Mill St, Fertile, MN 56540, 218-945-3220

(Consent to use PHI) Notice of Privacy Practices-Acknowledgement & Consent and Informed Consent for Chiropractic Care

Print Patient Name____

Use of Privacy Practices and Informed Consent

Your Protected Health Information(PHI) will be used by Hanson Chiropractic Clinic or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

You should review the Notice of Privacy Practices located on the front desk or on our website for a more complete description of your rights as they concern the limited use of health information, including you demographic inform, collected from you and created or received by this official You may review information collected from you and created or received by this office. You may review the Notice prior to signing this consent.

______I have received a copy of the Notice of Patient Privacy Policy

______Dr. Hanson may share information with my family or_____________________.

Requesting a Restriction on the Use or Disclosure of Your Information

-You may request a restriction on the use or disclosure of your PHI.

-This office may or may not agree to restrict the use or disclosure of your PHI.

-If we agree to your request, the restriction will be binding with this official Use or disclosure of PHI in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your PHI. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Informed Consent for Chiropractic Care

You should review the Notice of Informed Consent to Treat located on our front desk for a more complete notice of risks and complications related to chiropractic care. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. I understand that if I am accepted as a patient by this clinic, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me by request.

By my signature I give permission to leave a message on my answering machine and/or cell phone.
Cell phone #____

By my signature below I give my permission to use and disclose my information. I also give my consent to receive chiropractic treatment.

____ ____________________
Patient or Legally Authorized Individual Signature Date

____ ____________________
Witness Date