Hillclimb Chiropractic Clinic Consent for Use and Disclosure of Health Information (HIPAA)

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Matt Brown-Ruegg, DC PS DBA Hillclimb Chiropractic Clinic is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: ____

Address: ____

Telephone: ____________________ Email: ____________________

SECTION B: TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Content: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and/or healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of our protected health information, and of other important matters about your protected health information. A copy of our privacy policy is available upon request and on our website. We encourage you to read it carefully and completely before signing this consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information we maintain.

Our Notice of Privacy Practices is available in full on our website at http://www.hillclimbclinic.com/new-patients/. Also, you can request a copy of our Notice of Privacy Practices, including any revisions by calling/emailing: (206)624-3590 or info@hillclimbclinic.com

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the email address above. Please understand that revocation of this consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or continue treating you if your revoke or decline this consent.

SIGNATURE

I, ____________________(Print Name), have had full opportunity to read and consider the contents of this Consent for and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: ______________________________ Date: ____________________

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ______________________________

Relationship to Patient: ______________________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT- AVAILABLE UPON REQUEST