Chiropractic Health And Wellness Center

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NOTICE OF PRIVACY PRACTICES

Acknowledgement and Consent

Acknowledgement and Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information
Your Protected Health Information will be used by the Chiropractic Health And Wellness Center, LLC or may be disclosed to others for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices
You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction of Consent on the Use or Disclosure of Your Information

- You may request a restriction of consent on the use or disclosure of your Protected Health Information
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent
You may revoke consent to the use or disclosure of your Protected Health Information. 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.

By my signature below I give my permission to use and disclose my health information.

_____ I **HAVE NOT** requested a/an
- Restriction of Consent on the Use or Disclosure of my Protected Health Information
- Method of Alternative Communications
- Objection to the Notice of Privacy Practices

_____ I **HAVE** requested a/an
- Restriction of Consent on the Use or Disclosure of my Protected Health Information
- Method of Alternative Communications
- Objection to the Notice of Privacy Practices

Signature: _____ Date:_____

Print Name: _____ Date:_____

Witness: _____ Date:_____