Patient Acknowledgment receipt for consent to use and disclosure of Protected Health Information.

Use and disclosure of your Protected Health Information

Your PHI (Protected Health Information) will be used by Buller Chiropractic Clinic to authorize and disclose to others for purposes of treatment, obtaining payment, or health care operations of this office.

Notice of Privacy Practices

The undersigned acknowledges receipt of a copy of the current Notice of Privacy Practices for this health care facility. It describes your rights to the limited use of protected health information, including your demographic information.

You have the right to request a restriction or disclosure on the use of your PHI (Protected Health Information). This office may or may not agree to your request.

This office utilizes open or common areas for treatment; however, private areas are available upon request. You may refuse to sign this acknowledgment and authorization and revoke this consent to use PHI. This must be done in writing.

I authorize contact from this office to confirm my appointments, treatment, and billing information by means:

Patient Acknowledgment Contact

☐ Cell phone ☐ Home phone ☐ Text message

☐ Email ☐ All of the above

Phone Carrier: _____ (i.e. Sprint, Verizon, AT&T, etc.)

I acknowledge receipt of a copy of the office "Notice of Patient Privacy Policy"

_____ _____

Patient or legal authorized individual signature Date

_____

Printed name of Patient

_____ _____ _____

Sign Guardian of Patient Relationship Date

Office use only- As compliance officer, attempt to obtain patient's signature of this was not obtained because:

_____

Signature of Privacy officer