

# ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I, \_\_\_\_\_ (patient's name) acknowledge that I can request a copy and agree to the Notice of Privacy Practices of Rethwisch Family Chiropractic, P.C., which describes the practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

## **Patient Consent to Use and Disclose Health Information (Consent for Purposes of Treatment, Payment and Healthcare Operations)**

I consent to Rethwisch Family Chiropractic, P.C. ("the Practice's") use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present or future physical or mental health or condition, the provision of health care to me, or reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Practice, but that Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I understand I have the right to review the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing at any time, except to the extent that Physician of the Practice has acted in reliance on this consent.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Name of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Personal Representative's Authority

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## RIGHT TO REVOKE CONSENT

On this \_\_\_\_ day of \_\_\_\_\_, 200\_\_, I am using my right to revoke this consent. I understand that this revocation applies only to Protected Health Information given as of the date of revocation.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Name of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Personal Representative's Authority