Patient # __________ (office use only)

<u>Higley Family Chiropractic</u>

Consent for Use And/Or Disclosure of Protected Health Information

Your signature on this HIPAA compliance form indicated that you have read and agree with the following:

1. Protected heath information may be used and or disclosed in order to carry out treatment, payment, or heath care operations.

2. Notification of this office's privacy practice (including a complete description of uses and/or disclosures necessary to carry out treatment, payment, and/or health care operations) is available at patient request.

3. This office reserves the right to change its privacy practices (in accordance with applicable law) and will make available any and all revisions to privacy practice.

4. You have the right to request that this office restrict how your protected health information is used/disclosed to carry out treatment, payment, and/or health care operations.

5. This office is not required to agree to any restrictions that you have requested. Restriction requests are not honored in the care of worker's compensation.

6. If this office agrees to requested restrictions of health information, then the restriction is binding in the office.

7. You have the right to revoke this consent, in writing, at any time for all future transactions with the understanding that any such revocation shall not apply to past practices and is only applicable to practices forthwith.

8. Should you revoke this consent, this office retains the right to refuse treatment based upon the revocation and future lack of consent.

I have read and understand this notice and all of my questions have been answered to my full satisfaction.

Name of Individual (Please Print) ____

Signature of the Individual ____

Signature of Legal Guardian (if applicable) ______________________________________

Relationship ______________________________________

Date __________________________ Witness ______________________________