ORIGINAL

Thompson FAMILY CHIROPRACTIC

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Herriman, UT 84096
Telephone: 801.446.6220 Fax 801.446.2166

Consent for use of Disclosure of Health Information

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider if it is necessary to refer you to them for diagnosis, assessment or treatment.
- We may have to disclose you health information and billing record to another party if they are potentially responsible for the payment of your services.
- We may need to disclose your health information to an insurance company for benefits and or payments.
- We may need to use your health information within our practice for quality control or other operational purposes.
- We may need to use your personal information to remind you of your appointment, send you a birthday card, send a thank you for your referral card, acknowledge your referral on an in-office referral board, send you a welcome letter, invite you to participate in patient appreciation day, send you an office newsletter, or send you promotional informational.

- **Please provide your email address for monthly newsletters. (optional)**
  _____ email address

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come for treatment or by mail. Please fell free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to you restrictions. However, if we agree with your restrictions the restriction is binding upon us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have the right to your health information if they decide to **contest any of your claims.**

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

PRINT NAME:_____

SIGNATURE:_____ DATE:_____