Irwin Family Chiropractic Clinic, Inc.

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

HIPAA

At Irwin Family Chiropractic Clinic, Inc., the protection of your privacy is of utmost importance. 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:

1. We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to him/her for the diagnosis, assessment, or treatment of your health condition.
2. We may have to disclose your health information and billing records to another party if he/she is potentially responsible for the payment of our services.
3. We may need to use your health information within our practice for quality control or other operation purposes.

We reserve the right to change our privacy practices. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel 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 restriction on the use or disclosure of your health information, please let us know in writing. Under the law, we are not required to agree to such requested restriction; however, we will make every attempt to do so.

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 your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if it decides to contest any of your claims.

I have read this consent policy and agree to its terms.

PATIENT SIGNATURE _____________________________ DATE _______________________