THIS NOTICE PERTAINS TO PRIVACY MEASURES AT AlphaCare Health Chiropractic & Nutrition PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION
TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

With my signature below, I give consent for AlphaCare Health Chiropractic & Nutrition to use and/or disclose information about me (or someone else for whom I have the legal authority to sign) that is protected under federal privacy law for the sole purpose of treatment, payment, and health care operations.

I have reviewed the Privacy Policy of this Practice prior to signing this consent. The Privacy Policy may be amended from time to time, and I may always obtain a copy of the current policy without charge by asking for it.

I have the right to request restriction on how my information is used and/or disclosed in order to execute treatment, payment, or healthcare operations. While the Practice is not required to agree to restrictions, the Practice is bound to adhere to any such restrictions to which it has agreed.

I understand that the Practice operates with a semi-open adjusting area, where others can hear my voice and words. I agree to refrain from discussion of my protected health information in this open environment, and I agree to reserve discussions of protected health information for a private environment such as phone consultation, email consultation, or in-person consultation during non-adjusting hours.

I understand that AlphaCare Health Chiropractic & Nutrition has an email address shared amongst staff for patient communication regarding administrative matters, including scheduling and payment.

I have the right to revoke this consent in writing. Revocations will be honored from the time written and delivered to the Practice, but revocation cannot affect action already taken in reliance upon the consent given.

I realize that my personal information that is protected by federal privacy law may be used and/or disclosed at my consent, and that the information may be subject to re-disclosure by the recipient. Federal privacy law may not protect the re-disclosure by said recipient.

The Practice may communicate confidential information to me, including any invoices for services, at the following address/phone/text/fax number/e-mail address:

Patient Name:_____

Address:_____

Phone:_____ Email:_____

The Practice may communicate confidential information about me to the following individual(s):

Name:_____ Phone:_____ Email:_____

Name:_____ Phone:_____ Email:_____

_____ _____/_____/_____