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 condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is reasonable basis to believe the information can be used to identify me.

I authorize S.V.C.C., P.A. D/B/A Greenspan Chiropractors to discuss my Protected Health Information with ___________________. This authorization is valid until _______________or until further notice.

☐ I consent to S.V.C.C., P.A. D/B/A Greenspan Chiropractors use and discloser of my Protected Health Information for the purposes of providing treatment to me and relating to payment of services rendered to me. Health care 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 evidence by my signature on this document.

☐ Your chiropractor and staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form you are authorizing us to contact you with these reminders and information.

☐ In this office there may be a time when it is necessary for open therapy. This means that in the uncommon case one therapy room may have multiple therapies in use.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone viewing it and may no longer be protected by the privacy rules.

You may inspect or copy information used under this authorization. This notice is effective as of the date below. This authorization will expire seven years after the date which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I also may request a copy of this authorization.

I understand I have to 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 the Physician or the Practice has acted in reliance on this consent.

__________________________________ ___________________________

Patient name printed Date

____
____

Patient signature Authorized provider
representative

____
____

Personal representative printed Personal representative signature

____ Description of personal

representative's authority to act for the patient

(Parent, guardian, etc.)