Fefles Family Chiropractic
11555 South Harlem Ave., Suite C
Worth, IL 60482

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION RELATED TO: TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

Name: _____

Date of Birth: _____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses treatment and any plans for future care or treatment. **This information is kept private except uses involved in your healthcare.**

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and prior health information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that:

- I have the right to object to the use of my health information for directory purposes.
- I have access to a copy of the "Notice of Patient Privacy Rights" and they are available in the office.
- I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations, and that the organization is not required to agree to the restrictions requested.
- I have the right to revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.
- I have the right to request a copy of my records. I understand this requires 48 hours notice.
- I understand that the information used or disclosed pursuant to this authorization may be subject to being disclosed again my recipient and that this information will no longer be subject to protection as protected health information.

I request the following additional restrictions to the use or disclosure of my health information:

_____

I authorize Fefles Family Chiropractic to speak with the following people regarding my healthcare:

_____

With my consent Fefles Family Chiropractic may call my home or other designated location, and leave a voice message in reference to any items that assist the practice in carrying out treatment, payment and healthcare operation, such as appointment reminders, insurance items and information pertaining to my clinical care.

With my consent Fefles Family Chiropractic may send a narrative to my primary care doctor explaining my evaluation and treatment plan.

_____ _____

Signature of Patient/Legal Representative Date