Consent for Purposes of Treatment, Payment and Healthcare Operations

Patient Name _____ Birth Date_____

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I consent to the use or disclosure of my protected health information by Dr. Michael R. Petchauer for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Petchauer Chiropractic. I understand that Dr. Michael R. Petchauer may refuse to diagnose or treat me, if I do not consent to the use or disclosure of my protected health information for the above stated purposes. (My signature on this document is evidence of this consent.)

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Dr. Michael R. Petchauer agrees to a restriction that I request, the restriction is binding on Petchauer Chiropractic and Dr. Michael R. Petchauer.

I understand I have the right to review Dr. Michael R. Petchauer's Notice of Privacy Practices prior to signing this document. Dr. Michael R. Petchauer's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Petchauer Chiropractic. The Notice of Privacy Practices for Petchauer Chiropractic is also provided on request at the main administration desk of this practice and on Dr. Michael R. Petchauer's website at www.drpetchauer.com. This Notice of Privacy Practices also describes my rights and Dr. Michael R. Petchauer's duties with respect to my protected health information.

Dr. Michael R. Petchauer reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing Dr. Michael R. Petchauer's website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

I authorize my physician and/or administrative and clinical staff to disclose the following protected health information to:

Name: _____ Relationship to patient _____

Phone (___)_____ Cell (___)_____ Work (___)_____

Name: _____ Relationship to patient _____

Phone (___)_____ Cell (___)_____ Work (___)_____

Select the Protected Health Information (PHI) to be used or disclosed to the above listed individual(s) from the list below:

- ❑ Medical care/Treatment/Appointment: Yes _____ No____
- ❑ Can a message be left on your answering machine: Yes ____ No___

I have the right to revoke this consent, in writing at any time, except to the extent that Petchauer Chiropractic or Dr. Michael R. Petchauer has taken action in reliance on this consent.

_____ _____

Patient Parent Guardian (Circle one) Date