

**GREEN BAY CHIROPRACTIC CLINIC
MAUREEN O'CONNOR, D.C.
515 S. MILITARY AVE
GREEN BAY, WI 54303**

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

OUR PRIVACY PLEDGE: We are very concerned with protecting your privacy. 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. We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition. We may have to disclose your health information and billing records to another party if they are potentially responsible for the payments of your services. We may need to use your health information within our practice for quality control or other operation purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (164.520). We reserve the right to change our privacy practices as described in that notice. 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 restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Substance Use Disorder (SUD) Patient Records or Part 2: In general, Part 2 programs cannot share any information that would identify someone as having or having had, a substance use disorder unless Part 2 specifically permits it. With limited exceptions, such as for emergency medical treatment, records may only be shared if the patient gives consent or there is a court order and subpoena (or similar legal mandate). With your consent, we may use your information to treat you, bill for our services, fulfill your requests to share information to other healthcare providers for further treatment, diagnosis, assessment, etc. More information can be found in our lobby.

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 received your request to revoke 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 they decide to contest any of your claims.

APPOINTMENT REMINDERS AUTHORIZATION: Your chiropractor and members of the practice 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 including billing. 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 giving us authorization to contact you with these reminders and information.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care. You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives or other health related information at any time.

I have read your Consent Policy and agree to its terms. I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this notice.

Signature: _____ **Date:** _____

Patient's Name: _____

Signature of Parent or Guardian (If a minor): _____