Patient Consent to the use and Disclosure of Health Information For Treatment, Payment, or Healthcare Operations

I,____, understand that as a part of my health care, Charleston Chiropractic Center originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis to my bill,
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Privacy Polices that provides a more complete Description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care options.

I understand that Charleston Chiropractic Center is not required to agree to the restrictions requested.
I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164-506 of the Code of Federal Regulations.

I further understand that Charleston Chiropractic Center reserves the right to change their notice and practices and prior to implementation, in accordance with Section 1 64-520D of the Code of Federal Regulations. Should Charleston Chiropractic Center change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

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I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept the terms of this consent.

__________________________	__________________________
Patient signature	**Witness signature**
__________________	__________________
Date	Date