PATIENT HEALTH INFORMATION CONSENT FORM

THIS CONSENT DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures: We will use and disclose some or all of your Protected Health Information, hereby referred to as, (PHI) in the following ways **without needing your signed authorization:**

- Treatment: We will provide Chiropractic care at this office that includes adjustments and a variety of physiotherapies, exercises, home instructions, muscle treatments, examinations, x-rays, medical referrals, etc.
- Payments: We will use your PHI when communicating with your health insurance companies, workers compensation office, Medicare/Medicaid and attorney (with the proper authorization received).
- When the PHI is required by law, including judicial settings, law enforcement agencies and health regulatory agencies.
- In emergency situations to avert serious health/safety situations.
- To medical examiners, coroners or funeral directors to aid in identifying you or to help them perform their duties.
- To organ, tissue and other donation organizations, upon or proximate to your death.
- When there are other licensed or non licensed Doctors of Chiropractic or Chiropractic students working within this clinic.

Special cases:

- We may contact you about appointment reminders, treatment alternatives and other health care benefits and services. These may include postcards, letters and news letters.
- If we are fundraising for ourselves.
- To the sponsor of your health care plan.
- When referring you to another health care provider after discussion with you.

Other:
All other uses and disclosure by us will require us to obtain from you a written authorization in addition to any other permission you will provide us.

Your rights: You have the following rights concerning your PHI:

Restrictions: To request restricted access to all or part of your PHI. To do this please submit in writing your specific request that is signed and dated.

Confidential communications: To receive confidential information or correspondence by alternate means or to a different location simply submit your request in writing to this office. Please sign and date the request.

Access: You have the right to inspect your file or to receive copies of your PHI. To receive a copy of your file (including billing) submit the request in writing. Please sign and date the request. You will be required to pay a fee of $5.00 and will receive the copies no later than 30 days.

Amendments: To request changes to be made to your PHI please submit those requests in writing. Under law we are not required to make those changes, but will notify you of our decision in writing.

Accounting: To receive an accounting of all disclosures made by this office of your PHI that are outside of the standard disclosures that do not require your written authorization please submit a request in writing. Your files will be kept for a minimum of 6 years or longer depending on state and Federal law.

Updates of this notice: To receive updates of this notice please simply request the notice at the the front desk or submit it in writing.

Complaints: If you feel your HIPAA writes have been violated you may register a complaint with this office or the U.S. Dept. of Health and Human Services. The law forbids us from taking retaliatory action against you if you complain.

Our duties: We are required by law to maintain the privacy of your PHI. We must abide by the terms of this notice or any update of this notice.

Privacy contract: For more information about our privacy practices you can obtain our Notice of Privacy Practices at our office. Please contact Dr. Austin Faccone, D.C., 201 W. Arrowood Rd. Suite EE, Charlotte, NC 28217.

Effective date: This notice is effective as of May 1, 2009.

I acknowledge reading and understanding how my PHI may be used and agree to these policies and procedures:

Sign: ______________________________ Print: __________________________ Date: ___________________

If you are signing as the patient's representative:

Describe Authority: ____________________ Patient Name:_________________________________