

Skocik Chiropractic P.C.
5431 Old Jonestown Road
Hbg, Pa 17112
(717) 540-8448
Fax (717) 540-6233

Consent for use or Disclosure of Health Information/ Appointment Reminders/ Ongoing Communication

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 respect the privacy of your health information.

Here are several circumstances in which we 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 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 payment of your services.

We may need to use your health information within our practice for quality control or other operational purposes.

Your chiropractor and members of the practice staff may use your health information including your names, address, phone number and your clinical records for the purposes listed below. We are specifically requesting authorization to market the following products and/ or services to you:

- o Birthday and Holiday cards
- o Flowers on certain occasions
- o Patient newsletters
- o Posting names for referring others
- o Displaying testimonials and photographs with your implied permission, by filling out the testimonial
- o Electronic mail newsletters (if applicable) and E-Mail

We have 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 and 164.24). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify in writing when you come in for treatment or by mail. 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 restriction, the restriction is binding on us.

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 already released your health care information before we received your request to revoke your 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.

I have read your consent policy and agree to its terms, I am also acknowledging that I have received a copy of this notice.

Printed Name

Authorized Provider Representative

Signature

Date

Date