**HIPAA CONSENT FORM**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) require a healthcare facility to obtain a patient's written consent before using of disclosing the patient's personal health information (PHI) to carry out treatment, payment, or health care operations.

**Please read the consent statement below and sign that you understand its provisions:**

* **The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care.**
* **The patient has a right to review our Notice of Privacy Practices for Protected Health Information.**
* **The patient has a right to request restrictions with the use of an authorization form.**
* **The patient has a right to request in writing to copy or inspect certain PHI.**
* **The patient has a right to revoke consent in writing.**

We *want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read our complete* ***HIPAA Notice of Privacy Practices for Protected Health Information*** *that is available to you at the front desk before signing this consent.*

I have read and give consent to treatment under the HIPAA provisions of the office.

Signature:

Printed Name:

Date: