

Midwest Chiropractic Center
1198 Front Street
Tonganoxie, KS 66086
(913) 369-0022

Health Insurance Portability & Accountability Act (HIPAA) Consent Form

THIS NOTICE DESCRIBES HOW HEALTH RELATED INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

In the course of your care as a patient at our office, we may use or disclose personal and health related information about you in the following ways: 1. Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment. 2. Your health records as well as your billing records may be disclosed to another party, such as insurance carrier or your employer (if they are responsible for payment.) 3. Your name, address, phone number and your health records may be used to contact you regarding appointment reminders and a message may be left on your answering machine. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with authorization, it will not affect the care provided to you. Under federal law we are also permitted to use or disclose your health information without your consent or authorization in the following circumstances:

- If we are providing health care services to you based on the orders of another health care provider.
- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

We normally provide information about your health care to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account.

By signing below I acknowledge that I have read the above information and give full disclosure of my information.

Patient/ Guardian Signature

Date