

Patient Acknowledgment receipt for consent to use and disclosure of Protected Health Information.

Use and disclosure of your Protected Health Information

Your PHI (Protected Health Information) will be used by Buller Chiropractic Clinic to authorize and disclose to others for purposes of treatment, obtaining payment, or health care operations of this office.

Notice of Privacy Practices

The undersigned acknowledges receipt of a copy of the current Notice of Privacy Practices for this health care facility. It describes your rights to the limited use of protected health information, including your demographic information.

You have the right to request a restriction or disclosure on the use of your PHI (Protected Health Information). This office may or may not agree to your request.

This office utilizes open or common areas for treatment; however, private areas are available upon request.

You may refuse to sign this acknowledgment and authorization and revoke this consent to use PHI. This must be done in writing.

This office utilizes text messaging to send out appointment reminders. I authorize contact from this office to confirm my appointments, treatment, and billing information by means of:

Patient Acknowledgment Contact

- Cell phone
- Home phone
- Text message
- Email
- All of the above

I acknowledge receipt of a copy of the office "Notice of Patient Privacy Policy"

Patient or legal authorized individual signature	Date
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Printed name of Patient

Sign Guardian of Patient	Relationship	Date
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Office use only- As compliance officer, attempt to obtain patient's signature of this was not obtained because:

Signature of Privacy officer