FREITAG
FAMILY CHIROPRACTIC

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT

Freitag Family Chiropractic LLC is committed to patient privacy and the confidentiality of personal health information entrusted to us.

The ways in which we may use or disclose your health information are detailed in the Notice of Privacy Practices, a copy of which is located on our New Patient Forms Page on our website: www.freitagfamilychiropractic.com. You may also request a copy of this document from our office.

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, we will provide you with a Limitation of Use and Disclosure of Protected Health Information Request form.

Your Right to Request that Your Patient Record be Amended: You have the right to request that we amend the information in your patient record. If you would like to amend any information in your record we will provide you with a Request to Amend Protected Health Information form.

Your Right to Revoke Your Authorization: You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive 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.

YOU HAVE A RIGHT TO REFUSE CONSENT FOR DISCLOSURE OF YOUR PERSONAL HEALTH INFORMATION. WITHOUT YOUR CONSENT, HOWEVER, FREITAG FAMILY CHIROPRACTIC LLC WILL NOT BE ABLE TO DISCLOSE IMPORTANT INFORMATION TO OUTSIDE HEALTH CARE PROVIDERS IN THE EVENT OF AN EMERGENCY OR COORDINATION OF CARE.

Initial here [ ] I acknowledge review of the Freitag Family Chiropractic - Notice of Privacy Practices.

By signing below, I give consent to Freitag Family Chiropractic clinicians or staff to use or disclose my personal health information as noted in the Notice of Privacy Practices.

Patient Printed Name _____ Date ____ / _____ /_____

Patient Signature _____

Guardian Name & Relationship _____ Date ____ / _____ / _____

Guardian Signature_____