BAIRD CHIROPRACTIC CENTER, INC
CONSENT FOR USE OR DISCLOSURE OF PERSONAL HEALTH INFORMATION

Our Privacy Policy

We at Baird Chiropractic Center are very concerned with protecting your privacy. While the law now requires us to give you this disclosure, please understand that we have always respected the privacy of our patient's health information.

There are several circumstances in which we may 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 the diagnosis, assessment, or treatment of your health conditions.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of services you receive.
- We may have to disclose your health information within our practice for quality control or other operational purposes.

We have provided a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review the provided notice before you sign this consent form (164.520). 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 you in writing when you come in for treatment or by mail.

The 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 restrictions, the restriction is binding to us.

The Right to Revoke Your Authorization

You may revoke your consent 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.

I have read your patient privacy policy and agree to the terms. I am also acknowledging that I have received a copy of this notice. Initial _____

Patient Name - Printed Date

Patient Signature

Personal Representative - Printed Signature

Description of Personal Representative's Authority to act for the patient

My health information may be disclosed to the above individuals:

Emergency Contact and Relationship Contact Number

Home: Cell: Work:

Phone numbers Baird Chiropractic Center may leave messages at

Staff witness signature: