Davenport Family Chiropractic
1120 Mars Hill Rd, Suite 105, Watkinsville, GA 30677
Phone: 706-310-0575, Fax: 706-310-0576

Patient Consent for Use/Disclosure of Health Care Information

Patient's Name: _____ Date of birth: _____

I understand that my health information is private and confidential. I understand that Davenport Family Chiropractic (DFC) works very hard to protect my privacy and preserve the confidentiality of my personal health information (PHI).

I understand that DFC may use and disclose my PHI to help provide chiropractic health care to me, to handle billing and payment, and to take care of the other chiropractic care operations. In general, there will be no other uses and disclosures of this information unless I authorize it in writing. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual.

DFC has a detailed document call the "Notice of Patient Privacy Policy." It contains more information about the policies and practices protecting our patient's privacy. I understand that I have the right to read the "Notice" before signing this agreement. DFC may update the "Notice of Patient Privacy Policy" at any time. If I ask, DFC will provide me with the most current "Notice". Under the terms of this consent, I can ask DFC to limit how my personal health information is disclosed to carry out treatment, payment, or health care options. I understand that DFC does not have to agree to my request. If DFC does agree to my request, I understand that they will follow the agreed limit.

- Our Privacy Policy states that we may discuss our PHI to others who may assist in your care, such as your spouse, children, parents, or caregiver. **Please list any family members and caregivers with whom we are authorized to discuss your health care or to whom we may release your medical records.**

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_____

_____ **No**, I do not authorize release of information to family/caregivers.

Patient's Rights
I understand that I may cancel this consent by submitting a written, signed and dated letter to DFC. The letter must say that I want to revoke my consent to authorize the use and disclosure of my PHI for treatment, payment and chiropractic health care operations. If I revoke this consent, DFC does not have to provide further chiropractic health care to me.

My signature below indicates that I have been given the chance to review a current copy of DFC's "Notice of Patient Privacy Policy. " My signature means that I agree to allow DFC to use and disclose my PHI to carry out treatment, payment and chiropractic health care operations.

_____ _____
Patient or Legally Authorized Individual Signature Date

_____ _____
Print Patient's full name Date