HIPAA Consent Form

Preliminary draft subject to change

[This form does not constitute legal advice and is for educational purposes only. This form is based on current federal law and subject to change based on changes in federal law or subsequent interpretive guidance. This form is based on federal law and must be modified to reflect state law where that state law is more stringent than the federal law or other state law exceptions apply.]

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the user or disclosure of my protected health information by Hogue Chiropractic Center for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of Hogue Chiropractic. I understand that diagnosis or treatment of me by the doctors of Hogue Chiropractic Center may be conditioned upon my consent as evidence by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Hogue Chiropractic Center is not required to agree to the restrictions that I may request. However, if Hogue Chiropractic Center agrees to a restriction that I request, the restriction is binding on Hogue Chiropractic and the doctors of Hogue Chiropractic Center.

I have the right to revoke this consent in writing at any time, except to the extent that the doctors of Hogue Chiropractic Center or Hogue Chiropractic Center has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan my employer or a healthcare clearinghouse. This protected health information related to my past, present or future physical or mental health or condition and indentifies me, or there is a relasonable basis to believe the information may identify me.

I understand I have a right to review Hogue Chiropractic Center Notice of Privacy Practices prior to signing this document. Hogue Chiropractic Center Privacy of Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations of Hogue Chiropractic Center is also provided at 174 Barnwood Dr. Edgewood, KY 41017. This Notice of Privacy Practices also describes my rights and Hogue Chiropractic Center duties with respect to my protected health information.

Hogue Chiropractic Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by accessing Hogue Chiropractic Center, calling the office and requesting a revised copy to be sent in the mail or asking for one at the time of my new appointment.

This is to acknowledge that I have been given the opportunity to review Hogue Chiropractic Notice of Privacy Practices.

Signature of patient or personal representative:
_____

Date: _____

HIPAA Consent for Minor's

Signature of minor's personal representative: _____

Relation to minor: _____

Date: _____