Patient Consent for Use and Disclosure of Protected Health Information

Horning Chiropractic Center

I hereby give my consent for Horning Chiropractic Center to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

Horning Chiropractic Center's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Horning Chiropractic Center reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Maria Rubino, Horning Chiropractic Center, 127 Ark Road, Store #19, Mt. Laurel, NJ 08054.

With this consent, Horning Chiropractic Center may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Horning Chiropractic Center may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, Horning Chiropractic Center may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Horning Chiropractic Center restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Horning Chiropractic Center's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Horning Chiropractic Center may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Patient's Name Date

_____
Print Name of Patient or Legal Guardian

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

HORNING CHIROPRACTIC CENTER

I, _____ have read a copy of Horning Chiropractic Center's
Patient name

Notice of Patient Privacy Practices.

_____ _____
Signature of Patient or Parent or legal Guardian

Date