

Richart Chiropractic and Functional Medicine
2 Northfield Plaza, Suite 204
Northfield, IL 60093
847-657-8686

PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (“PHI”) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of you Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing the Consent, and has encouraged me to read the Privacy Notice prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable laws.
3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) postcard mailed to me at the address provided by me; and b) telephoning my home, work or cell phone and leaving a message on my answering machine or with the individual answering the phone; and c) contacting via the e-mail address provided by me.
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
7. For you security and right to privacy, all staff has been trained in the area of patient

record privacy and a privacy official has been designated to enforce those procedures in our office. The Practices has taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

8. I understand I have the right to file a formal complaint with the privacy official about any possible violations of these policies and procedures.

9. I understand if I am referred by an individual, the Practice may mail a postcard or send a letter to the individual acknowledging the referred. Only my name will be used. No other PHI will be given.

10. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

11. I understand that if I do not sign the Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Name of Patient (Printed)

Signature of Patient

Signature of Legal Representative (Parent of a Minor)

Date Signed ____/____/____