**CROCKER CHIROPRACTIC, LLC**
464 North Jefferson Ave., Lebanon, MO 65536
(417)532-9166

## *Consent to use PHI*

**Acknowledgement for Consent to Use and Disclosure of Protected Health Information**

**Use and Disclosure of your Protected Health Information**

Your Protected Health Information will be used by Crocker Chiropractic, LLC or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

**Please list those whom we may give your information to:**

Name: _____ Phone#: _____
Name: _____ Phone#: _____
Name: _____ Phone#: _____

**Notice of Privacy Practices**

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office.

I have **received** a copy of the Notice of Patient Privacy Policy. _____Patient Initials

**Requesting a Restriction on the Use or Disclosure of Your Information**

You may request a restriction on the use or disclosure of your Protected Health Information.
This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

**Notice of Treatment in Open or Common Areas**

Note that some of your treatment may be performed in an "open area". Private areas are available upon request to discuss your health information upon request. _____Patient Initials

**Revocation of Consent**

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

***By my signature below I give my permission to use and disclose my health information.***

| | |
|---|---|
| Patient or Legally Authorized Individual Signature | Date |
| Print Patient's Full Name | Time |
| Witness Signature | Date |