Fuhr Chiropractic Clinic
3714 E. Indian School Rd. Phoenix, AZ 85018
Dr. Eric Petermann D.C.

OUR PROMISE OF PRIVACY AND CONSENT TO PATIENT RECORDS

Our office is fully committed to compliance with HIPPA guidelines by:

1. Providing appropriate *security* for our patient records.
2. Protecting the *privacy* of our patient's medical information.
3. Providing our patient's with proper *access* to their medical records.
4. Appropriately maintaining our patient information and billing processes in compliance with national *standards*.

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patient's consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already taken which relied on this or a previously signed consent.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

Name: _____ Phone: _____
(Print Authorized Person(s) Name Here)

This consent was signed by: _____
(Print Your Name Here)

Signature: _____ Date: _____
(Sign Your Name Here)

Witness: _____ Date: _____