Bordentown Chiropractic Clinic
231 Crosswicks Rd, Ste 1A, Bordentown, NJ 08505 (609) 298-9820

HIPAA LAW # 101-191 CONSENT FORM

The information you provide us is kept in the strictest of confidence. While protecting your privacy is extremely important to us, there may be certain situations in which we may have to use or disclose your healthcare information.

1. It may be necessary to use or disclose your private health information to another healthcare provider or hospital, if it is necessary to refer you to them for diagnosis, assessment or treatment.

2. It may be necessary to use or disclose your private health information and billing records to another party if they are responsible for the payment of services.

3. It may be necessary to use or disclose your private health information within our practice for quality control and operational purposes including:
    - Appointment reminders at home, work or cell phone and leaving a message if necessary on machine or with another person or with a reminder card or post card.
    - Sending you a newsletter, marketing materials, information on alternative treatments or any other health information that may be of interest to you.
    - Sending you a Thank You gift.
    - Testimonials of your improvement in writing or verbal form as well as a Family picture Board.

Patient Rights Under HIPAA LAW # 101-191

1) You have the right to request that we do not disclose your private health information to specific individuals, companies, or organizations under the following circumstances:
- All requests must be in writing
- By law we are not required to agree with your restrictions, however, if we agree with your restrictions then the restriction is binding to us.

2) You have the right to REVOKE your authorization under certain conditions:
- It must be in writing.
- The request will not be honored if we have already released your private health information before we received your request to revoke authorization.
- If you were required to give your authorization as a condition of obtaining insurance, the insurance may then have the right to your private health information should they decide to contest any of your claims. Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone that has access to the remainder of other information and may no longer be protected by the federal privacy rules.
- If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for services rendered to you.

I have read your consent policy and agree to its terms. I also acknowledge that once I sign this consent form, I will receive a copy of this completed form for my own records. This notice is effective on the date below and will expire seven years after the date upon which the record was created.

_____	_____	_____
Patient Name Printed	Patient Signature	Date
_____	_____	_____
Personal Representative Printed	Personal Representative Signature	Authorized Provider Representative

NOTE: We have a more detailed “Notice of Privacy for Private Health Information” and you have the right to review the detailed notice before you sign a consent form. We have the right to change our privacy practices as described in the detailed notice. If any changes occur in reference to our policy practices you will be notified by posting of the change in our office or a notice will be sent to you in the mail. You may request a copy of our privacy notices at any time.