Consent For Use And Disclosure Of Information

I have reviewed the "Notice of Privacy Practices" of **Santiago Family Chiropractic** and have had all questions answered by this office.

I also consent to the use or disclosure of my protected health information for the following purposes:

- **Treatment**

It will be necessary to share protected health information with all members of the treatment team for treatment purposes. This can include employees in this office as well as other providers.

- **Payment**

Necessary information will be shared with appropriate payer sources and their representatives for payment purposes including, but not limited to, eligibility, benefit determination, and utilization review. It will also be necessary for your billing personnel, including, but not limited to, employees, case managers, claims representatives, third party billing services of clearinghouses to have access to protected health information to carry out their job functions.

- **Healthcare Operations**

Necessary information will be shared for the continuing operations of this office. Some examples include, but are not limited to, peer review, accreditation, credentialing processes and compliance with all federal laws.

I understand that my treatment may be conditioned upon my consent. This consent is given freely and I understand that I can revoke this consent at any time in writing which will apply to disclosures and uses made subsequent to the revocation date.

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Patient Name (Printed) **Date**

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Patient Signature (or Guardian)