Caputo Chiropractic

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we will always respect the privacy of your health information.

* We may have to disclose your health information to another health care provider to refer you to them for the diagnosis, assessment or treatment of your condition.

* We may have to disclose your health information to another party if they are responsible for the payment of your services.

* We may need to disclose your billing information and clinical records to the Chiropractic Society of Rhode Island if we need their assistance to receive reimbursement for your services or if your insurance carrier has improperly processed your claim.

* We may need to contact you with appointment reminders, information about treatment alternatives or other health related information that may be of interest to you. If this contact if made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

* We are specifically requesting to be able to contact you by mail with a thank you note for referring patients to our practice.

Your right to revoke this authorization

You may revoke your consent to us at any time; however your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I may receive a copy of this notice by request.

_____ _____

Printed Name Authorized Provider Representative

_____ _____

Signature Date

_____

Date