Indy Health & Wellness Center

Patient Health Consent Form

Your rights concerning your Patient Health Information (PHI) are important to us. Please review the privacy policies carefully. If you would like a copy of this consent form for your records please ask at the front desk.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, and healthcare operations. As an example, the patient agrees to allow this office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies required for payment.
2. The patient has the right to examine and obtain a copy of their own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient after the request has been presented.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given after the request has been presented.
5. For your security and right to privacy, we have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. If the patient refuses to sign this consent for the purpose of treatment, payment and healthcare operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

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Printed Name of Patient

Our office is unable to discuss your Patient Health Information with any individual including spouses and relatives. If you would like to give authorization for your PHI to be discussed with a specific individual, list their name(s) below and provide your signature to give our office authorization.

_____ _____

_____ _____

X_____

Signature of Patient (or parent if patient is under 18 years old) Date

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