Health Information Patient Privacy

Patient Name_____Date_____

Patient Signature_____

In connection with the chiropractic services I am receiving, I hereby authorize Dr. Diane Grant and her respective agents and staff to disclose any/all information concerning my condition and treatment (including but not limited to, confidential information concerning, mental health, sexually transmitted diseases, chemical dependence, or other vital information). including copies of applicable medical, diagnostic, or hospital records, too;

A. Any third party covering health care service of a patient.

B. Other health care professionals and institutions involved in the delivery of health care to the patient.

C. The proponent of any legally sufficient subpoena, or in response to a court order.

D. Employees and agents of the practice to the degree necessary to facilitate the provision of health care services and payment for such services:

E. Pharmacies, and

F. As otherwise required by law.

When providing information to me, information may be transmitted by any and all of the following means. (Initial all that apply):

_____Telephone message on an answering machine or voice mail
_____E-mail, newsletter.
_____Postcards, written matter.
_____Messages to the following family members or friends.

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In each case the practice will oversee the minimum necessary information disclosed in accordance with the above. I further understand that I have been given access to the physician's privacy notice and that I have had the opportunity to place special instructions upon the consent hereby given:

SPECIAL INSTRUCTIONS

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