Draeger Chiropractic

Patient Health Information Consent Form

This form is to obtain your consent to Draeger Chiropractic, S.C. the use and disclosure of your protected health information to carry out treatment, payment activities and health care operations.

In this document, "I", "me" or "my" refer to the patient and "Chiropractor", "our", "us" or "your" refers to Dr. David D. Draeger or Draeger Chiropractic, S.C.

- I have been provided the opportunity to receive a copy of our Notice of Privacy Practice. I have the right to read this Notice before I decide whether to sign this consent. **Initial here ( )**

- I consent to the use or disclosure of my protected health information by the Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operation of the Chiropractor. I understand that analysis, diagnosis or treatment of me by the Chiropractor may be conditioned upon my consent as evidenced by my signature below.

- I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The Chiropractor is not required to agree to the restrictions that I may request.

- This consent is effective unless and until it is revoked by you in writing. Such revocation will *not* affect any action we took in reliance to this consent before we received you revocation. Upon revocation we may decline to continue treating you.

- This consent is a condition of your treatment by us. If you decide not to sign this consent, we may decline to treat you.

Signature

I, _____, have had the opportunity to read and consider the contents of this consent form and your Notice of Privacy Practice. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Patient Signature: _____ Date: _____

If this consent is signed by a personal representative (ie. Parent/Guardian, POA) on behalf of the patient, complete the following:

Representative's Name: _____Relationship to Patient: _____

Dr. David D. Draeger, DC
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