DESERT MOUNTAIN HEALTH CENTER, INC.
CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Privacy Pledge

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

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other internal operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restriction on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your 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 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 have received a copy of this notice.

____ ____
PATIENT NAME PRINTED AUTHORIZED PROVIDER REPRESENTATIVE

____ ____________________________
PATIENT OR GUARDIAN SIGNATURE DATE

____
GUARDIAN NAME PRINTED/RELATION TO PATIENT

____
DATE

DESERT MOUNTAIN HEALTH CENTER, INC.
APPOINTMENT REMINDERS & HEALTHCARE INFORMATION AUTHORIZATION

Your chiropractor and members of the staff may need to use your name, address, phone number, email address (if provided by you), and clinical records to contact you with appointment reminders or rescheduling, information about treatment alternatives, birthday cards, or other health related information that may be of interest to you. If this contact is made by phone and you do not answer, 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/or information.

You may restrict the use of your information by our office. We assure you we will not give this information to any other persons or companies for the purpose of marketing. You may revoke your authorization at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already used that information before we receive your request to revoke.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

This notice is effective as of ______________________. This authorization will expire seven years after the date on which you last received services from us.

I authorize Desert Mountain Health Center to use or disclose my health information in the manner described above.

____ I am also acknowledging that I have received a copy of this authorization.

______________________________ ______________________________

PATIENT NAME PRINTED AUTHORIZED PROVIDER REPRESENTATIVE

______________________________ ____________________

PATIENT OR GUARDIAN SIGNATURE DATE

____

GUARDIAN NAME PRINTED/RELATION TO PATIENT

____

DATE