

## PATIENT HIPPA AWARENESS

With my permission, Touch of Life Chiropractic East, P.C. (TLCEAST), may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to TLC East Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. TLC East reserves the right to revise its Notice of Private Practices at any time. A revised edition may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of TLC East may call my home or other designated locations and leave a message on voice mail or in person in reference to any items and any call pertaining to my clinical care, including x-rays, MRI's and other diagnostic testing.

With my permission, TLC East, may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked personal or confidential. I have the right to restrict how, TLC East, uses or disclose my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

It is the practice of this office to provide chiropractic care in an "open adjusting" environment. "Open adjusting" involves several patients being seen in the same adjusting room at the same time. Patients are within site of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. Patient histories, examinations or presenting report of findings are procedures that are completed in private, confidential settings. If you choose not to be adjusted in an open environment, other arrangements will be made for you. Your decision will have no adverse affect on your care from the doctor or on your relationship with our staff.

By signing this, I am allowing TLC East, to use and disclose my PHI for TPO as noted above.

I may revoke me consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

Patients Name: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Patient/Guardian: \_\_\_\_\_