HIPAA Disclosure Form

Purpose of Consent

This Consent for the use and/or disclosure of personally identifiable health information is made pursuant to the requirements of 42 C.F.R. §164.506, which sets out the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

Please read the following information carefully:

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by Allison Family Chiropractic (the "Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the regulations.

2. I am aware that the Practice maintains a Privacy Notice which sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing this Consent, I understand and acknowledge that I have the right to review the Privacy Notice prior to signing this Consent.

4. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me, but if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing. I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (**leave blank if no restrictions**): ______________________________
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5. I understand and acknowledge that I may revoke this Consent at any time by sending a written revocation to the Practice at the address set forth in (3) above. However I also understand and acknowledge that if I revoke this Consent, my revocation will not be effective to the extent that the Practice has already acted action in reliance on this Consent.

   I understand the foregoing provisions, and I wish to sign this Consent authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations.

By signing this form I acknowledge that I have reviewed this consent and agree to the practice's use and disclosure of my protected health information for treatment, payment, and healthcare operations.

______________________________ ______________
Patient or Guardian Signature Date

______________________________ ______________
Witness Date