

## Patient Health Information

There are several circumstance 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 operational purposes.

We have a policy that provides a detailed description of how your health information may be used or disclosed. You have the right to review that policy before you sign this form (164.520). We reserve the right to change our privacy practices as described in that policy. If we make a change to our privacy practices, we will notify you when you come in for your treatment or by mail. Please feel free to call us at any time for a copy of our privacy policy.

### YOUR RIGHT TO LIMIT USES OR DISCLOSURES

You have the right to request that we do not disclose your health to specific individuals, companies, or organizations. If you would like to place any restrictions on the use of disclosures 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 descriptions, the restriction is binding on us.

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not home, 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 information. Furthermore, we may use your name in any "in office" usages, including but not limited to: Promotions, educational materials, patient referral boards, and travel cards.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us 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 released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have the right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the remainder of other information and may no longer be protected by the federal privacy rules.

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

You may inspect or copy the information we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (164.524).

This notice is effective as of April 15, 2003. This authorization will expire seven years after the date on which you last received service from us.

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 received your request to revoke your 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 consent any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that a copy of this notice is available.

\_\_\_\_\_  
Patient Name

**NorthEast Spine & Sports Medicine, P.C.**  
**1104 Arnold Avenue**  
**Point Pleasant, New Jersey 08742**

\_\_\_\_\_  
Signature

**2080 West County Line Road**  
**Jackson, NJ 08527**

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Date