NOTICE: Patient Privacy

Santa Clara Chiropractic Center

We are committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information and to provide you with notice describing:

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION

We are required by law to have your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization.

As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information and complaining if you think your rights have been violated.

We have available a detailed NOTICE OF PRIVACY PRACTICES which fully explains your rights and our obligations under the law. We may revise our NOTICE from time to time. The effective date at the bottom left hand side of this page indicates the date of the most current NOTICE in effect.

You have the right to receive a copy of our most current NOTICE in effect. If you have not yet received a copy of our current NOTICE, please ask at the front desk and we will provide you with a copy.

If you have any questions, concerns or complaints about the NOTICE or your medical information, please contact Dr. Scott Aley, DC.

Effective Date: 5/18/15

Santa Clara Chiropractic Center
Dr. Scott Aley, DC
2620 River Rd. Suite E, Eugene, OR 97404
541-688-3223

CONSENT TO USE OR DISCLOSE MEDICAL INFORMATION

I authorize Dr. Scott Aley, DC, to use and disclose the health and medical information of _____ for the purposes of Treatment, Payment and Health Care Operations.

(Patient Name)

Treatment (includes activities performed by Dr. Aley, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers my proactive as the on-call physician)

Payment (includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, precertification and preauthorization)

Health Care Operations (includes the necessary administrative and business functions of our office)

Your may review Dr. Scott Aley, DC "NOTICE OF PRIVACY PRACTIVES" for additional information about the uses and disclosures of information described in this CONSENT prior to signing this CONSENT. Please verify that you have received a copy of your NOTICE by placing your initials here _____.

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the NOTICE may change also. A summary of the NOTICE will be posted in the lobby of our office indicating the effective date of the NOTICE in the lower left hand corner. We will provide you with a copy of the NOTICE upon your request.

As more fully explained in the NOTICE, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. *We are not required to agree to your request.* If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment. Other physicians who provide on-call coverage for our office are required to use and disclose your protected health information consistent with the NOTICE.

I understand that I have the right to revoke this CONSENT provided that I do so in writing, except to the extent that Dr. Scott Aley, DC has already used or disclosed the information in reliance on this CONSENT.

_____ _____ (OR)

Date Signature of patient

_____ _____

Date Signature of patient's Parent or Guardian

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