

SAILER FAMILY CHIROPRACTIC  
234 Pinecone Road  
Sartell, MN 56377

320-253-5255

## ***Notice of Privacy Practices - Acknowledgement & Consent***

### **Acknowledgement for Consent to Use and Disclosure of Protected Health Information**

#### **Use and Disclosure of your Protected Health Information**

Your Protected Health Information will be used by Sailer Family Chiropractic or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

#### **Notice of Privacy Practices**

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

#### **Requesting a Restriction on the Use or Disclosure of Your Information**

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

#### **Revocation of Consent**

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

***By my signature below I give my permission to use and disclose my health information.***

\_\_\_\_\_  
*Patient Signature*

\_\_\_\_\_  
*Date*

## ***Assignment and Informed Consent***

*If you have any questions concerning this form, please ask your doctor.*

Having carefully read the Assignment, Informed Consent, and understand the information. I hereby give my informed consent to have chiropractic treatment, acupuncture treatment and massage administered.

***By my signature below I agree to the Authorization/Assignment, and Informed Consent.***

\_\_\_\_\_  
*Patient Signature*

\_\_\_\_\_  
*Date*