Note: Your health information will be kept strictly confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential my Medicare

PRIVACY CONSENT FORM/REQUIRED BY FEDERAL HIPPA LAW #101-191

For Use of Disclosure of Private Health Information

Trust in the foundation of a doctor/patient relationship.
The information that you provide us is kept in the strictest of confidence
While protecting your privacy is extremely important to us, there may be certain situations in which we may have to use or disclose your private health information.

1. It may be necessary to use or disclose your private health information to another health care professional or hospital if it is necessary to refer you to them for the diagnosis, assessment or treatment of your health situation.

2. It may be necessary to use or disclose your private health care information and billing records to another party if they are responsible for the payment of your services.

3. I may be necessary to use or disclose your private health information within our practice for quality control and operational purposes.

Please note:
We have a more detailed "Notice of Privacy for Private Health Information" and you have the right to review the detailed notice before you sign this consent form. We have the right to change our privacy practices as described in the detailed notice. If any changes occur in reference to our privacy practices, you will be notified by a posting of the change in the office or a notice will be sent to you in the mail. You may request a copy of our privacy notices at any time.

Patient rights under HIPPA Law 101-191

1. You have the right to request that we do not disclose your private health information to specific individuals, companies or organizations under the following circumstances:
   - **a. All Requests must be in writing.**
   - **b. By law we are not required to agree with your restrictions HOWEVER:**
   - **c. If we agree with your restrictions, the restriction is binding on us.**

2. You have the right to REVOKE your Authorization under certain conditions:
   - **a. It must in writing.**
   - **b. the request will not be honored if we have already released your private health information before we received your request to revoke the authorization.**
   - **c. If you were required to give our authorization as a condition of obtaining insurance, the insurance carrier may have the right to your private health information should they decide to contest any of your claims.**

I have read your consent policy and agree to its terms. I also acknowledge that once I sign this consent form I will receive a copy of this completed form for my own records.

______________________________	**Jeffrey LePoidevin, D.C.**
Printed Patient Name	**Printed Authorized Provider Name**
______________________________	______________________________
Signature	**Signature**
______________________________	______________________________
Month/Day/Year	