Denver Headache & Spine Center P.C.
1501 W. Campus Dr., Suite I
Littleton, CO 80120
303-795-7530

HIPAA Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the **Health Insurance Portability and Accountability Act of 1996 (**a.k.a. **HIPAA or The Healthcare Privacy Act)**. I understand that by signing this consent I authorize you to use and/or disclose my protected health information to carry out the following:

- Treatment which includes direct and/or indirect treatment by other healthcare providers involved in my treatment.
- Obtaining payment from third party payers, i.e. my medical insurance company/companies.
- The day to day healthcare operations of your chiropractic practice.

I have also been informed of, and given the right to review and secure a copy of your ***Notice of Privacy Practices***, which contains a more complete description of the uses and disclosures of my protected personal health information, and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may request the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to use these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent will not be affected.

____ ____________________
Patient’s Name Printed Date

____ ____________________
Signature of Patient or Responsible Party Relationship to Patient