

**Consent for Disclosure of Health Information Authorization**

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have and always will respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health information.

- We may have to disclose your health information to another provider (Primary physician) 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 and billing information to another party if they are potentially responsible for the payment of services.
- We may need to use your health information within our practices for quality control purposes.
- We may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information on treatment alternative, or other health related information that may be of interest to you.
- We may need to use your name, address, phone number and your clinical records for the purpose of sending birthday/holiday cards, newsletters, etc.

**Right of revocation and limited use**

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

You have the right to request that we do not disclose your information to specific individuals, companies or organizations. If you would like to place any restrictions on the use of or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However if we agree to your restrictions it is binding on us.

You may also 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 prior to receiving your request. 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 contest any of your claims.

You may inspect or copy the information that we use to contact you at any time (§164.524).

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (§164.520). We reserve the right to change our privacy practices as described in that notice. If we make any changes we will notify you in writing when you come in for treatment or by mail.

This notice is effective as of \_\_\_\_\_. This authorization will expire seven years after the date you last received services from us.

TOLLAND FAMILY CHIROPRACTIC, LLC  
392 D Merrow Road Tolland, CT 06084  
(860) 872-7771

I authorize you to use or disclose my health information in the manners described above.  
I am also acknowledging that I have received a copy of this information.

\_\_\_\_\_  
Printed name

\_\_\_\_\_  
Authorized Provider Representative

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Personal representative name printed

\_\_\_\_\_  
Personal representative signature

\_\_\_\_\_  
Relation