Family Chiropractic Center
Dr. Catherine Silver-Riddell, D.C.
PO BOX 340
Inwood, WV 25428
Phone: (304) 229-5846 Fax: (304) 229-5849

Consent for Purposes of Treatment, Payment, and Health Care Operations

I consent to the use or disclosure of my protected health information by Family Chiropractic Center for the purposes of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Family Chiropractic Center. I understand that diagnosis or treatment of me by Dr. Catherine Silver-Riddell, D.C. may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Family Chiropractic Center is not required to agree to the restrictions that I may request. However, if Family Chiropractic Center agrees to a restriction that I request, the restriction is binding on Family Chiropractic Center and Dr. Catherine Silver-Riddell, D.C.

I have the right to revoke this consent in writing, at any time, except to the extent that Dr. Catherine Silver-Riddell, D.C. or Family Chiropractic Center has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Family Chiropractic Center's Notice of Privacy Practices prior to signing this document. The Family Chiropractic Center's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Family Chiropractic Center. The Notice of Privacy Practices for Family Chiropractic Center is also posted at the front desk. This Notice of Privacy Practices also describes my rights and the Family Chiropractic Center's duties with respect to my protected health information.

Family Chiropractic Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or by asking for one at the time of my next appointment.

_____ _____
Signature of Patient or Personal Representative Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority