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Dr. John Cianciolo CHIROPRACTIC PHYSICIAN

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HIPAA CONSENT/AUTHORIZATION

Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires our office to obtain written patient consent before disclosing Protected Health Information (PHI). We respect the privacy of your health care information. Below is a list of circumstances in which we may have to use or disclose your health information.

We may have to disclose your health information to other healthcare providers or hospitals for assessment, diagnosis or treatment of your health condition.
We may have to disclose your health information and billing records to another party if they are potentially responsible for payment of services. (ie. Insurance co., Attorney, Third Party Liability)
We may need to use your health information within our practice for quality control or other operation purposes.

I also authorize Dr. John Cianciolo and his staff to use my name, address, phone number, and clinical records to contact me via telephone or mail for the purpose of:

Mailing you a "Thank you" letter for referring a patient with an enclosed gift certificate to Modern Pizza. Your name may be listed on our office newsletter. Mailing you a missed appointment card.
Telephoning you at home or on cell phone to remind you of an appointment or missed appointment. A message may be left on the answering machine or with the person answering the phone.
Telephoning you at work if we need to reschedule an appointment due to inclement weather or office emergency.

We have a HIPAA Office Log, which provides a detailed description of how your health information may be used or disclosed. You have the right to review the log before you sign this consent/authorization form. You also have the right to limit uses or disclosures of your health information. You may also revoke your consent at any time in writing. This consent/authorization form is effective as of Sept. 23, 2013 and will expire seven years after the date on which you last received services at your office.

I have read the consent/authorization form and agree to its terms. I also acknowledge being provided with a copy of the Notice of Privacy Practices.

_____
PATIENT NAME PRINTED

_____
WITNESS SIGNATURE

_____
PATIENT'S SIGNATURE

_____
DATE SIGNED