

KORDONOWY CHIROPRACTIC CENTER  
473 Hendersonville Road, Suite C  
Asheville, NC 28803

(828) 277-0903

**Consent to use PHI**

**Acknowledgement for Consent to Use and Disclosure of Protected Health Information**

**Use and Disclosure of your Protected Health Information**

Your Protected Health Information will be used by KORDONOWY CHIROPRACTIC CENTER or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

**Notice of Privacy Practices**

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy. \_\_\_\_\_ Patient Initials

**Requesting a Restriction on the Use or Disclosure of Your Information**

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

**Notice of Treatment in Open or Common Areas**

Describe and Notify private areas available upon request

**Revocation of Consent**

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

***By my signature below I give my permission to use and disclose my health information.***

\_\_\_\_\_  
Patient or Legally Authorized Individual Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Patient Full Name

\_\_\_\_\_  
Time

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

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**Patient Authorization**

**Standard Authorization of Use and Disclosure of Protected Health Information**

**Information to Be Used or Disclosed**

The information covered by this authorization includes:

Appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you.

**Persons Authorized to Use or Disclose Information**

Information listed above will be used or disclosed by:

Kordonowy Chiropractic Center

Name of Person Organization

**Expiration Date of Authorization**

This authorization is effective through \_\_\_\_\_ unless revoked or terminated by the patient or patient's personal representative.

**Patient Rights**

**Right to Terminate or Revoke Authorization**

You may revoke or terminate this authorization by submitting a written revocation to this office and contact the Privacy Officer.

**Potential for Re-disclosure**

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

I understand this office will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure.

***If you understand and agree with all of the above policies, please sign your name below.***

\_\_\_\_\_  
Patient or Legally Authorized Individual Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Patient Full Name

\_\_\_\_\_  
Time

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date