Acknowledgment 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 Connect 2 Health Wellness Centers, LLC or disclosed to others for the purpose of treatment, botaining 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 more complete description of how your Protected Health Information may be used to 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. You may review the Notice prior to signing this consent, you may request a copy of the Notice at the front desk.

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 Protect Health Information. If we agree to your request, the restrtiction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of federal privacy standards.

Revocation of Right to Change in Privacy Practice

The office reserves the right to modify the privacy practices outlines in the Notice.

Media Release

We will be using social media outlets to promote Connect 2 Health Wellness Centers, LLC. We will be using sources such as Twitter, Facebook, Instagram, and the Connect 2 Health website. Please be aware that some media used may have photo attachments. Please check the appropriate box.

[ ] I give Connect 2 Health Wellness Centers, LLC Staff permission for picture/video and name to be published Media outlets pertaining to Connect 2 Health Chiropractic Wellness Centers, LLC.

[ ] I do not give permission for my picture/video and name to be published on any social media.

_____

Patient Name (Print) Date

_____

Signature of Patient Date

_____

Signature of Patient Representative Relationship Date

_____

Office Representative Date

_____

Others we may release PHI to Relationship