

# CONSENT TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Auburn Chiropractic, P.A.

21 Millett Drive

Auburn, ME 04210

Phone: (207)782-2600, Fax: (207)782-1331

I hereby consent to the release of information about my health condition and the care and treatment I receive from Auburn Chiropractic, P.A. for the following purposes:

**Treatment** – I understand that Auburn Chiropractic, P.A. will provide my protected health information (“PHI”) to other health care professionals directly involved in my care so that they may understand my health condition and needs.

**Payment** - I understand that Auburn Chiropractic, P.A. will provide my PHI, directly or through a billing service, to appropriate third party payors according to their billing and payment requirements in order to get paid for services provided to me.

**Health Care Operations** - I understand that Auburn Chiropractic, P.A. may compile, use and/or disclose my PHI to the extent necessary to operate in accordance with applicable law and insurance requirements and to continue to provide quality and efficient care.

I understand that a more complete description of how Auburn Chiropractic, P.A. uses or discloses my PHI and my privacy rights under law appears in Auburn Chiropractic, P.A.’s Notice of Privacy Practices. I understand that I have a right to review the Notice of Privacy Practices before I sign this consent. I also understand that Auburn Chiropractic, P.A. reserves the right to change the terms of the Privacy Notice and to make the new terms applicable to my PHI so long as I have been provided with advance notice of the revised Privacy Notice.

I understand that I have the right to request restrictions on certain uses and disclosures of my PHI. I also understand that Auburn Chiropractic, P.A. is not required to agree to a restriction I request. I understand that if Auburn Chiropractic, P.A. elects to agree to a restriction I request, that agreement is binding on Auburn Chiropractic, P.A.

I understand that I have the right to revoke this consent in writing, except to the extent that Auburn Chiropractic, P.A. used or disclosed my PHI in reliance on my prior consent. I also understand that Auburn Chiropractic, P.A. may condition treatment on my consent to the use and disclosure of my PHI for the purposes set forth in this consent form.

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(Patient Name — Please Print)

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(Signature of Patient or Legally Authorized Representative) (Date)

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(If Legally Authorized Representative, Please Explain Relationship to Patient)