MISSION CHIROPRACTIC
6556 Johnson Dr.
Mission, KS 66202
913-432-4780

Acknowledgment of receipt of Notice of Patient Privacy Practices (HIPPA)

I, _____ give consent to Mission Chiropractic & Wellness to use and disclose my Protected Health Information as per HIPPA law for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for Mission Chiropractic's general healthcare operation purposes. Healthcare operations shall include, but are not limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that Mission Chiropractic's diagnosis or treatment may be conditioned upon my consent as evidenced by my signature on this document.

Information will not be shared with any third party without patient's consent. Under extreme circumstances, information may be shared without patient's consent with sole purpose of best regards towards patient's treatment. A full expansion of these circumstances is available upon request.

For purposes of this consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present or future physical or mental health or condition: the provision of health care services to me; and either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment, or healthcare operations of the Practice, but the practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I have the right to revoke this consent, in writing, at any time except to the extent that the physician or Practice has acted in reliance on this consent.

Mission Chiropractic & Wellness reserves the right to change the privacy practices that are described in the NOTICE OF PATIENT PRIVACY PRACTICES. All changes will be posted in the clinic. I understand that I may request a copy of this notice at any time.
The most current copy of this notice will be posted in the clinic.

_____ _____

Signature of Patient or Personal Representative Date