SOULWAVE CHIROPRACTIC STUDIO
DR. ERIN POLLINGER

Consent to Use or Disclose Medical Information

I authorize ***Dr. Erin Pollinger*** to use and disclose the health and medical

information of _____ for the purpose of Treatment, Payment, and
Patient Name
Health Care Operations.

Treatment *includes activities performed by a physician, nurse, office staff and other types health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers my/our practice by telephone as the on-call physician.*

Payment *includes activities involved in determining your eligibility for heath plan coverage, billing, and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, precertification, and preauthorization.*

Health Care Operations *includes the necessary administrative and business functions of our office.*

You may review Soulwave Chiropractic Studio's ***"Notice of Privacy Practices"*** for additional information about the uses and disclosures of information described in this CONSENT prior to signing the CONSENT. Please verify that you have received a copy of our ***Notice*** by placing your initials here:_____.

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the notice may change also. We will offer you a copy of the ***Notice*** on your first visit to us after the effective date of the then current ***Notice***. We will also provide you with a copy of the ***Notice*** upon your request.

As more fully explained in the ***Notice***, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. We are not required to agree to your request. If we do agree, we are required to comply with your request unless the information is needed to provide your emergency treatment. Other physicians who provide call coverage for our office are required to use and disclose your protected health information consistent with the ***Notice***.

I understand that I have the right to revoke this CONSENT provided that I do so in writing, except to the extent that Soulwave Chiropractic Studio has already used or disclosed the information in reliance on this CONSENT.

(or)

_____ _____
Date Signature of Patient

_____ _____
Date Signature of person authorized by law