

CONSENT OF DISCLOSURE

I hereby give consent to the office of Denton Chiropractic & Natural Health including all qualified doctors and staff, and all healthcare providers furnishing care within this office to use and disclose my protected health information for purposes of treatment, payment, and healthcare operations as stated in office policy, following HIPPA guidelines, and as allowed by law.

You have the right to cancel this consent at any time. Your cancellation must be in writing, signed by you or on your behalf, and delivered to the address at the bottom of this form. This may be delivered in person or by mail.

You have the right to request restriction on the usage and disclosure of your protected health information for the purposes of treatment, payment, or healthcare operations. We are not required to grant your request; however, if we do, the restriction is obligatory to us.

Our posted Privacy Policy provides more detailed information about the usage and disclosure of your protected health information. You have the right to review our posted Privacy Policy before you sign this consent.

We reserve the right to amend the terms of our Privacy Policy. You can obtain a copy of the current policy by requesting a copy from our Privacy Compliance Officer.

ACCEPTANCE

With this signature, I fully accept and understand the above mentioned consent of disclosure.

Print Patient Name: _____ Date: _____

Signature: _____

If you are signing as the patient's representative:

Print Patient Name: _____ Date: _____

Relationship: _____

Denton Chiropractic & Natural Health
520 East Center St. Marion, Ohio 43302
Phone: 740.387.3185 Fax: 740.387.4238