



COMMUNITY CHIROPRACTIC & ACUPUNCTURE

In accordance with the Health Insurance Portability and Accountability Act of 1996, patients of this practice are entitled to the greatest degree of privacy possible. This office will strive to ensure that patient information is used only for authorized purposes as agreed to by the patient. Patients are advised that they have a right to be given these copies upon receipt of payment if indicated. Patients are also entitled to request an amendment to their records.

Patient Consent

In connection with medical services that I receive from Dr. Karen A. Thomas, I hereby authorize that health care provider to disclose any/or all information concerning my medical condition and treatment, including copies of applicable hospital and medical records to:

- Any third party payer covering medical services of the patient (e.g. your health insurance carrier)
- Other health care professionals and institutions involved in the delivery of healthcare to the patient (e.g. referral for x-ray)
- The proponent of any legally sufficient subpoena, or in response to a court order
- Employees and agents of the practice, to the degree necessary to facilitate the provisions of health care services (e.g. the person who submits medical claims to your insurance carrier)
- Pharmacies
- Other parties as required by law.

In each case, the practice shall take reasonable steps to ensure that only the minimum necessary information is disclosed in accordance with the above.

PLEASE NOTE ANY SPECIAL RESTRICTIONS REGARDING THE RELEASE OF MY PERSONAL HEALTH INFORMATION.

Special Restrictions:

This consent is valid from date executed until revoked in writing by the patient.

Signed: _____ Date: _____

The person to contact regarding any of the above is Dr. Karen A. Thomas.