

# BELLEVUE CHIROPRACTIC CENTRE



Bill Walsh, DC  
Bridget Walsh, DC  
Richard MacDonald, DC

*“Improving Function, Improving Life”*

## Consent for Use or Disclosure of Health Information

While the Health Insurance Portability & Accountability Act (HIPPA) requires us to give you this disclosure, please understand that we are very concerned with protecting your privacy and will always respect the privacy of your health information. Bellevue Chiropractic Centre may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding to us. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

Upon request, you may receive a copy of this authorization. This authorization will expire seven years after the date on which you last received services from us.

I authorize Bellevue Chiropractic to use or disclosure my health information in the manner described above.

\_\_\_\_\_  
Patient Name Printed

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Personal Representative Printed

\_\_\_\_\_  
Personal Representative Signature

\_\_\_\_\_  
Description (parent,  
guardian, etc)

Bellevue Chiropractic Representative: \_\_\_\_\_

PHONE

FAX

WEB

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