

*THE HEALING ARTS CENTRE  
518 HILLGROVE AVENUE, SUITE 275  
WESTERN SPRINGS, IL 60558  
708-246-6022*

*PRIVACY POLICY  
EFFECTIVE 4/14/03*

**THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

In the course of your care as a patient at The Healing Arts Centre, we may use or disclose personal and health related information about you in the following ways:

\*Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.

\*Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer (if they are or may be responsible for the payment of your services).

\*Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, birthday postcards, newsletters, to provide information about alternatives to your present care, or to other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. **If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.**

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

\*If we are providing health care services to you based on the orders of another health care provider.

\*If we provide health care services to you in an emergency.

\*If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.

\*If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

\*If we are ordered by the courts or another appropriate agency.

4/2003

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**ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES**

**\*You May Refuse To Sign This Acknowledgement**

I, \_\_\_\_\_ have received a copy of this office's  
Notice of Privacy Practices.

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
**For Office Use Only**  
\_\_\_\_\_

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but  
acknowledgment could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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## CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

### SECTION A: PATIENT GIVING CONSENT

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_ E-MAIL: \_\_\_\_\_

PATIENT #: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

### SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting Dr. Sharon Garvey at 708-482-0155, Fax 708-482-0370, Address: 7 S. Waiola, LaGrange, IL 60525

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation.

### SIGNATURE

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If this Consent is signed by a personal representative on behalf of the patient, complete the following:  
Personal Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_