OREGON SPINE AND DISC

Dr. Joseph J. Hamlin - Dr. Heymi Choe Hamlin - Dr. Kris Dearborn
Member
Oregon Chiropractic Assoc.
Chiropractic Assoc. Of Spain
European Chiropractic Union

Patient Name:_____ ***DOB***:_____
Insurance:_____ ***ID#***:_____

5035 NE Elam Young Pkwy Blvd., Suite 300, Hillsboro, OR 97124 **Phone: 503.626.3700** Fax: 503.643.6667

HIPAA

Acknowledgement of receipt of Notice of Privacy Practice

Regarding the Use & Disclosure of Protected Health Information
("Consent Form")

For the purposes of this Consent Form, "Office" shall refer to: ***Oregon Spine and Disc***.

I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures I should refer to the Office's privacy notice entitled, "Our Privacy Practices." I understand that I may review this privacy notice at any time prior signing this form.

I understand that over time the Office's privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the notice as revised, I can call the Office to request such copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations, and that I can also revoke this Consent in, but only to the extent that the Office has not taken action in reliance thereon and also provided that I do so in writing.

I understand that for my protection, any requests to amend my health information or to access my medical records **must be made in writing.**

I have also given authorization to___ _____
(Person's name and relationship to patient)

to access information to my account.

Patient Name (please print): _____

Signature: _____ Date: ____/____/_____

IF PATIENT IS A MINOR

_____ Date: ____/____/_____
Signature of Patient Representative
(Required if patient is a minor or adult unable to sign this form)

Relationship to Patient _____