

**Enright Chiropractic, LLC**

**ACKNOWLEDGEMENT OF HIPAA PRIVACY NOTICE  
AND DESIGNATION OF DISCLOSURE**

**I. Acknowledgement of Practice's Notice of HIPAA Privacy:**

I have read a copy of the Notice of HIPAA Privacy for the Physician Practice

_____	_____	_____	_____
Name of Patient	Date	Signature of Patient/Parent Guardian	Date

**II. Designation of Certain Relatives, Close Friends and Other Caregivers:**

A. I agree that the practice may disclose certain of my health information to a family member, close personal friend or other caregiver, since such person is involved with my health care or payment relating to my healthcare. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my healthcare. I wish to be contacted in the following manner (check all that apply):

**Telephone, Written and Fax Communication**

Home Telephone Number \_\_\_\_\_

Written Communication:

\_\_\_\_ OK to leave message with detailed information

\_\_\_\_ OK to mail to my home address

\_\_\_\_ Leave message with call back numbers only

\_\_\_\_ OK to mail to my work/office address

Work Telephone Number \_\_\_\_\_

Fax Communication

\_\_\_\_ OK to leave message with detailed information

\_\_\_\_ OK to fax to this number \_\_\_\_\_

\_\_\_\_ Leave message with a call back number only

Other: \_\_\_\_\_

B. I designate the following persons listed below as persons involved with my healthcare or payment relating to my healthcare for the purpose of the practice making the limited disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this list at any time in writing.

Print Name: _____	Last four digits of his/her SS number (required) _____
Print Name: _____	Last four digits of his/her SS number (required) _____
Print Name: _____	Last four digits of his/her SS number (required) _____

C. The following person(s) are not authorized to receive my Patient Health Information:

Print Name: _____	Print Name: _____
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_____	_____
Signature of Patient/Parent/Guardian	Date

III. The privacy rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for, Patient Health Information to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the patient/parent/guardian. Healthcare entities must keep a record of Patient Health Information disclosures. Information provided below will constitute an adequate record. Uses and disclosures for Treatment, Payment, and Healthcare Operations may be permitted without prior consent.

Date of disclosure request	Disclosure to whom; address/fax number	Description of disclosure	Purpose of disclosure	Date of Service of disclosure	Person completing request	Date completed

CONSENT TO CHIROPRACTIC SERVICES

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic who now or in the future treat me while employed by, working or associated with or serving as a backup for the Doctor of Chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinic personnel the scope of practice, nature and purpose of chiropractic care: specifically manual care; adjustments and other procedures. I understand that with manual care, i.e., adjustments, there is a certain risk of but not all inclusion of: muscle or ligament strains or sprains, bony fractures, cerebral vascular or neurological insult.

I understand and am informed as to the nature and purpose of the procedures, possible alternatives, the risks involved, the possible consequences, and the possibility of complications have been explained to me by the below named Doctor of Chiropractic and/or his/her associates and assistants and do not expect the Doctor to be able to anticipate and explain all the risks and complications, and wish to rely on the Doctor to exercise judgment during the course of the procedure which the Doctor feels at the time, based upon the facts then known, is in my best interests.

\_\_\_\_\_  
Enright Chiropractic, LLC/Dr. James J. Enright

I have read, or have been read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

\_\_\_\_\_  
Print Patient's Name

Date \_\_\_\_\_

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

THE FOLLOWING IS TO BE COMPLETED BY PATIENT'S REPRESENTATIVE, IF NECESSARY, e.g., IF THE PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED:

\_\_\_\_\_  
Print Patient's Name

Date \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient's Representative

\_\_\_\_\_  
Relationship or Authority of Patient's Representative