**Boas Family Chiropractic**
479 Rt. 79, Suite #15
Morganville, NJ 07751
Tel: (732) 591-2580    Fax: (732) 591-1525

**PRIVACY CONSENT FORM/REQUIRED BY FREDERAL LAW #101-191**
**For use or Disclosure of Private Health Insurance (PHI)**

Trust is the foundation of a doctor/patient relationship.
The information that you provide us is kept in the strictest of confidence.
While protecting your privacy is extremely important to us, there may be certain situations in which we may have to use or disclose your health information:

1. It may be necessary to use or disclose your PHI to another health care provider or hospital if it is necessary to refer you to them for diagnosis, assessment or treatment of your health.
2. It may be necessary to use or disclose your PHI and billing records to another party if they are responsible for the payment of your service.
3. It may be necessary to use or disclose your PHI within our practice for quality control and operational purposes.

**Please Note:**

We have a more detailed "Notice of Privacy for Public Health Information" and you have the right to view the detailed notice before signing this document. If any changes occur in our privacy practices, you will be notified by a posting of changes in the office, or a notice will be sent to you in the mail.

**Patient Rights Under HIPPA LAW #101-191**

1. You have the right to request that we do not disclose your PHI to specific individuals, companies or organizations under the following circumstances:
   A. All requests must be in writing.
   B. By law, we are not required to agree with your restrictions, HOWEVER
   C. If we agree with your restriction, the restriction is binding on us.
2. You have the right to revoke your authorization under certain conditions:
   A. It must be in writing.
   B. The request will not be honored if we have already released your PHI before we received your request to revoke the authorization.
   C. If you were required to give your authorization as a condition of obtaining insurance, the insurance may have the right to your PHI should they decide to contest your claim.

**I have read your consent policy and agree to all terms:**

______________________________
Printed Patient Name

______________________________
Printed Authorized Provider Name

______________________________
Patient Signature

______________________________
Provider Signature

______________________________
Today's Date