Peoria Chiropractic
901 W. Glen Ave, Ste. A
Peoria, IL 61614

Tracie Khoury DC
Ryder Church DC
Dean Trotter DC
Brad Cotton DC

Patient Acknowledgement

For Use And/Or Disclosure Of Protected Health Information (PHI) To Carry Out Treatment, Payment And Healthcare Options

I, _____ herby state that by signing this consent, I acknowledge and agree as follows:
Print Name

1. Peoria Chiropractic's Notice of Privacy Practices has been provided to me prior to my signing this consent. The Notice of Privacy Practices include a complete description of the uses and/or disclosures of my Protected Health Information (PHI) necessary for Peoria Chiropractic to provide treatment to me, and also necessary for Peoria Chiropractic to obtain payment for that treatment and to carry out its health care operations. Peoria Chiropractic has further explained my right to obtain a copy of the Notice of Privacy Practices prior to signing this Consent and has encouraged me to read the Notice of Privacy Practices carefully prior to my signing this Consent.

2. Peoria Chiropractic reserves the right to change its privacy practices that are described in its Notice of Privacy Practices in accordance with applicable law.

3. Peoria Chiropractic's Notice of Privacy Practices is also provided in the waiting room. I may also request a copy from this office at any time via US Mail.

4. This Notice of Privacy Practices also describes my rights and the duties of this office with respect to my Protected Health Information (PHI).

5. Authorization to Release Medical Information to Family Members: I hereby give Peoria Chiropractic authorization to discuss my protected health information with Name: _____ Relationship: _____

Name: _____ Relationship: _____

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I understand.

_____ _____
Patient Signature Date

_____ _____
Signature of Legal Representative Relationship

_____
Witness