Apex Health Centers, LLC.

Notice of Privacy Practices * Acknowledgment

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes us to do so. You may see your record or get more information about it by contacting Moehrle Chiropractic Clinic.

Our Notice of Privacy Practices describes in more detail how your health information may be used or disclosed and how you can access your information.

Moehrle Chiropractic (The Practice), reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

I understand and consent to the method of use/disclosure of my PHI by The Practice to include but not limited to:

1) Email:(moehrleclinic@gmail.com): Lab Reports, Dr. Notes, Intake Forms/ID, Insurance information, Attorney Liens, etc.

2) Telephone: Appointment reminders by leaving a message on my voicemail or with the individual answering the phone.

The Practice may use and/or disclose my information about my health or condition and the treatment provided to me in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operation.

I understand that I have a right to request that the Practice restrict how my health information is used and/or disclosed to carry out treatment, for payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

I understand that this consent is valid for seven years. I further understand that I have the right to revoke this consent in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

I understand that if I do not sign this consent evidencing my consent to the uses and disclosures described to me above and contained in the privacy notice, then the Practice will not treat me.

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.

____
Name of Individual (Printed)

____
Signature of Individual

____
Date

____
Signature of Legal Representative (e.g., Attorney, Guardian/Parent for Minor)

____
Relationship

Witness: ________________________

Ashton Anwar
Chiropractic Physician

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