



Innergy, LLC
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Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office along with your rights concerning those records. Before we will begin any health care services, we require you to read and sign this consent form stating you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI, we encourage you to read the HIPPA NOTICE, which can be made available at your request, before signing this consent form.

1. The patient understands and agrees to allow this chiropractic office to use their PHI for the purpose of the adjustment, payment, health care operations, and coordination of care.
2. The patient has the right to obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. The patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. For your security and right to privacy, all staff members have been trained in the area of patient record privacy. We have take all precautions to assure that your records are not readily available to those who do not need them.
5. If the patient refuses to sign the consent for the purpose of adjustment, payment, and health care operations, the chiropractic doctor has the right to refuse care.

I have read and understand how my PHI will be used and I agree to these policies and procedures.

Signature: _____ Date: ____/____/____

Address: _____

City: _____ State: _____ Zip: _____

Home phone: (____) _____ Work Phone: (____) _____