VOITENKO WELLNESS
CHIROPRACTIC NUTRITION

HIPAA REQUIRED FORM

Patient consent to the use and disclosure of private health information for treatment. payment or healthcare operations.

I ____, understand that as a part of my healthcare, Dr. Amber Voitenko Chiropractic Offices originates and maintains paper and/or electronic records describing my health history, symptoms, examinations and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the health professionals who contribute to my care,
- A source of information for applying my diagnosis to my bill,
- A means by which a third party payer can verify that services billed were provided.

Should it become necessary to disclose my protected information to another health provider or 3rd party payer for the above purposes, I consent to such disclosure for these permitted uses, including disclosures via fax.

In addition, we may post your name on our "referral thank you" board, quarterly newsletter other printed material.

Patient Signature ______________________________ Date ______________________

THIS WILL BE FILED IN YOUR MEDICAL CHART

Voitenko Wellness
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