Dr. Darrell Murphy
St. Louis Sports
Chiropractic Center, P.C.
314-843-8590

Dr. Megan Floarke
Back in Motion Chiropractic
& Rehabilitation, L.L.C.
314-843-0005

Dr. Lacey Miller
Cardinal Chiropractic, L.L.C.
314-270-9299

12032 Tesson Ferry Rd., Suite 100, Saint Louis, MO 63128

Consent to Use Personal Health Information

Acknowledgment for Consent to Use and Disclose Protected Health Information

Use and Disclosure of Your Protected Health Information
Your Protected Health Information will be used by this practice or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day healthcare operations of this office.

Notice of Privacy Practices
You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office.

I have received a copy of the Notice of Privacy Practices. _____ ***(patient initials)***

Requesting a Restriction on the Use or Disclosure of Your Protected Health Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed-upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas
Describe and Notify Private Areas is available upon request.

Revocation of Consent
You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below, I give my permission to use and disclose my Protected Health Information.

_____ _____
Patient or legally authorized individual signature Date

_____ _____
Print patient full name Time

_____ _____
Witness signature Date