



**Chiropractic Offices of Gonstead, Stangl, and Arkowski LLCs**  
 O Dr. MJ Gonstead O Dr. Melissa Stangl O Dr. Lisa Arkowski O Dr. Jennifer Gonstead  
**503 E. Clairemont Ave • Eau Claire, WI 54701 • P: (715) 832-222**

**CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION**  
**Our Privacy Pledge**

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information (PHI). There are several circumstances in which we may have to disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.
- We may need to use your personal health information such as name, address, email or phone number to contact you with appointment reminders.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us any time for a copy of our privacy notices.

**Your right to limit uses or disclosures**

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

**Your right to revoke your authorization**

You may revoke your consent to us at any time; however, your revocations must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice, if I request it.

\_\_\_\_\_  
 Print Patient Name

\_\_\_\_\_  
 Authorized Staff Representative

\_\_\_\_\_  
 Patient or Parent's Signature

\_\_\_\_\_  
 Date

*I WOULD LIKE A COPY OF THIS HIPAA POLICY? YES NO (CIRCLE ONE)*

*PAPER COPY EMAIL (CIRCLE ONE)*