PATIENT CONSENT
FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION AND HEALTHCARE OPERATIONS

_____hereby states that by signing this consent, I acknowledge and agree as follows:

1. The practice's privacy notice has been provided to me prior to signing this consent the privacy notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the practice to provide treatment to me, and also necessary for the practice to obtain payment for that treatment and to carry out its healthcare operations. The practice explained to me the Privacy Notice will be available to me in the future at my request. The practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this consent, and encouraged me to read Privacy Notice carefully prior to signing this consent.

2. The practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand and consent to the following appointment reminders that will be used by the practice: a) a postcard mailed to me at the address provided by me; and b)telephoning my home and leaving a message on my answering machine or with the individual answering the phone.

4. The practice may use and/or disclose my PHI (which includes 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 healthcare operations.

5. I understand I have the right to request that the practice restrict how my PI II is used and/or disclosed to carry out treatment, payment, and/or healthcare 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.

6. 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.

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

8. I authorize and release the doctor and whomever he may designate as his assistant to administer treatment, physical examination, chiropractic care, or any clinic services that he deems necessary: and I to disclose all or part of my records to anyone who is liable under a contract to the clinic or to the patient or a family member or employer of the patient for all or part of the clinic's charge, including and not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or patient's employer.

9. 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 satisfaction in a way that I can understand.

Name of individual (Printed):_____ Signature of individual:_____

Signature of legal representative: _____ Relationship: _____

Date signed: _____ Witness: _____