

Consent and Receipt of Notice

I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review the practice/clinic's Notice of Privacy Practices before signing this consent.

I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notices in the practice/clinic at my request.

I understand that I have the right to request a restriction on how my protected health information is used. However, I also understand that the practice/clinic is not required to agree to the request. If the practice/clinic agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

I give permission to the practice/clinic to use my information to contact me regarding appointment notification or information about treatment alternatives, or other health related information.

I give permission to the practice/clinic to adjust me in an open area where other patients are also being adjusted. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the practice/clinic will provide a private room for these conversations.

Signature: _____ Date: _____

If signed by patient representative, state relationship to patient: _____