LAW CHIROPRACTIC CENTER

Dr. Christopher Law

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PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

With my signature below, I give consent for the **Law Chiropractic Center (The Practice)** to use/or disclose information about me (or someone else for whom I have legal authority to sign) that is protected under federal privacy law for the sole purpose of treatment, payment, and healthcare operations.

I have reviewed the Privacy Notice of **The Practice** prior to signing this consent and by signing this form I authorize **Law Chiropractic** to communicate with me in the methods stated. I also understand all privacy issues listed that pertain to my treatment, payment, and healthcare operations. The Privacy Policy may be amended from time to time, and I may always obtain a copy of the current policy without charge by asking for a copy.

I have the right to request restrictions on how my information is used and/or disclosed in order to execute treatment, payment or healthcare operations. While **The Practice** is not required to agree to restrictions, **The Practice,** is bound to adhere to any such restrictions to which it has agreed.

I have the right to revoke this consent in writing. Revocations will be honored from the time written and delivered to **The Practice**, but revocation cannot affect action already taken in reliance upon the consent given.

I realize that my personal information that is protected by federal privacy law may be used and/or disclosed at my consent, and that the information may be subject to re-disclosure by the recipient. The re-disclosure by said recipient may not be protected by federal privacy law.

I understand that this consent is valid for seven years.

Patient Name (Printed) _____

Patient Signature

_____

Date Signed _____ **Witness** _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes your spouse, children, step parents, grandparents and any care takers who can have access to this patient's records):

Name:_____ Relationship:_____ Phone Number:_____

Name:_____ Relationship:_____ Phone Number:_____

Name:_____ Relationship:_____ Phone Number:_____