

**PATIENT CONSENT FOR USE AND DISCLOSURE  
OF PROTECTED HEALTH INFORMATION**

With my consent, this office may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to our Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. This office reserves the right to revise its' Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to your doctor at 1340 Tuskawilla Rd. Suite 112, Winter Springs, FL 32708.

With my consent, The doctors at this office may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care.

With my consent, the doctors at this office may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders, and patient statements as long as they are marked Personal and Confidential.

I have the right to request that my doctor restricts how he uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, is bound by this agreement.

By signing this form, I am consenting to my chiropractor to have the right to use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, the doctors at this office may decline to provide treatment to me.

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Signature of patient or legal guardian

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Patient's name (please print)

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Date