

Patient Consent Form

Regarding the Use and Disclosure of Protected Health Information

(“Consent Form”)

For the purposes of this Consent form, “Office” shall refer to Mission Chiropractic, LLC.

I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures I should refer to the Office’s privacy notice entitled “Notice of Privacy Practices”. I understand that I may review this notice at any time prior to signing this form.

I understand that over time the Office’s privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the notice as revised, I can call the Office to request such copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations, and that I can also revoke this consent in, but only to the extent that the office has not taken action in reliance thereon and also provided that I do so in writing.

I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing.

Patient Name [please print] _____

Signature _____

Date ____/____/____