COMPREHENSIVE CHIROPRACTIC AND SPORTS INJURY CENTER, P.C.
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Consent for Release and Use of Confidential Information AND Acknowledgement of Notice of Privacy Practices.

I, _____ hereby
(Name of Patient or Authorized Agent)

give my consent to Comprehensive Chiropractic & Sports Injury Center, P.C. to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of:_____ .
(Name of Patient)

I acknowledge the review and/or receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be available to me upon a written request to the Privacy Officer.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in case where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

I understand that I have the right to request that the practice restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that the practice does not have to agree to such, but that once such restrictions are agreed to, the practice and their agents must adhere to such restrictions.

Signed:_____ Date:_____

If you are not the patient, please specify your relationship to the patient. _____