



## CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by Blue Ribbon Chiropractic (also BRC) for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of BRC. I understand that diagnosis or treatment of me by Donna B. Goodwin, D.C., may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Blue Ribbon Chiropractic is not required to agree to the restrictions that I may request. However, if BRC agrees to a restriction that I request, the restriction is binding on BRC and Donna B. Goodwin, D.C.

I have the right to revoke this consent, in writing, at any time, except to the extent Donna B. Goodwin, D.C. or BRC has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physicians, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review BRC's Notice of Privacy Practices prior to signing this document. The BRC's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practice describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of BRC. This Notice of Privacy Practice also describes my rights and BRC's duties with respect to my protected health information.

Blue Ribbon Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practice by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

\_\_\_\_\_  
Patient Signature

Date: \_\_\_\_\_

\_\_\_\_\_  
Witness for the Patient

Date: \_\_\_\_\_