FOSTER Family & Sports CHIROPRACTIC, L.L.C.

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CONSENT FOR PURPOSES OF TREATMENT, PAYMENT & HEALTHCARE OPERATIONS: I consent to the usage or disclosure of my protected health information by FOSTER Family & Sports CHIROPRACTIC for the purpose of diagnosing or providing treatment to me, obtaining the payment for my health care bills or to conduct health care operations of FOSTER Family & Sports CHIROPRACTIC. I understand that diagnosis or treatment of me by FOSTER Family & Sports CHIROPRACTIC may be conditional upon my consent as evidenced by my signature of this document.

I understand I have the right to request a restriction as to whom my protected health information is used or disclosed to carry out treatment, payment or healthcare operation of the practice. FOSTER Family & Sports CHIROPRACTIC is not required to agree to the restrictions that I may request. However, if FOSTER Family & Sports CHIROPRACTIC agrees to a restriction that I request the restriction is binding.

I have the right to revoke this consent, in writing, at anytime, except to the extent that FOSTER Family & Sports CHIROPRACTIC 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 physician, 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 FOSTER Family & Sports CHIROPRACTIC's *Notice of Privacy Practices* prior to signing this document FOSTER Family & Sports CHIROPRACTIC's *Notice of Privacy Practices* has been provided to me. *The Notice of Privacy Practices* describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of bills or in the performance of health care operations of FOSTER Family & Sports CHIROPRACTIC. The *Notice of Privacy Practices* so provided at the front office. *The Notice of Privacy Practices* also describes my rights and FOSTER Family & Sports CHIROPRACTIC's duties with respect to my protected health information.

FOSTER Family & Sports 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 Practices* 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.

____ ____________________
Signature of Patient/Personal Representative Date

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PRINTED NAME of Patient or Personal Representative

A photocopy shall be considered as effective and valid as the original.