CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

I acknowledge that Kurtz Chiropractic's "Notice of Privacy Practices" has been provided to me.

I understand I have a right to review Kurtz Chiropractic's "Notice of Privacy Practices" prior to signing this document. 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 my bills or in the performance of health care operations of Kurtz Chiropractic. The Notice of Privacy Practices for Kurtz Chiropractic is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Kurtz Chiropractic's duties with the respect to my protected health information.

I understand that Kurtz Chiropractic Center has the right to release my records to any facility that is used for the purposes of my treatment, payments for my treatment, or any other healthcare operation.

Kurtz 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 to be sent in the mail or by asking for one at the time of my next appointment.

I have the right to revoke this consent, in writing, except to the extent that Kurtz Chiropractic has taken action in reliance on this consent.

PATIENT ACKKNOWLEGMENT

By subscribing my name below, I acknowledge receipt of a copy of this notice, and my understanding and my agreement to its terms.

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

_____

Expiration Date