SHAPERO CHIROPRACTIC
CHIROPRACTOR TO THE USF ATHLETIC DEPARTMENT

300 MONTGOMERY STREET – SUITE 650
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(415) 397-2544

Daniel M. Shapero, D.C.
DOCTOR OF CHIROPRACTIC

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Associate in Chiropractic to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). (Associates in Chiropractic Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practice prior to signing this consent. Associates in Chiropractic reserves the right to revise its Notice of Privacy Practices ay anytime. A revised Notice of privacy Practices may be obtained by forwarding a written request to Associates in Chiropractic Privacy Officer at 300 Montgomery Street, Suite 650, San Francisco, CA 94104.

With this consent, Associates in Chiropractic may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Associates in Chiropractic explains how it uses or discloses my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosure in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Associates in Chiropractic may decline to provide treatment to me.

_____ _____
Signature of Patient or Legal Guardian Date

_____
Patient's Name

_____
Print Name of Patient or Legal Guardian