

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 any 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 204, 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