DELTA CHIROPRACTIC ASSOCIATES, INC.

Patient Consent Form
Regarding the Use & Disclosure of Protected Health Information

I understand that some of my health information may be used and/or disclosed be the Office to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures I should refer to the Delta Chiropractic Associates Inc. privacy notice entitled, "Notice of Privacy Practice." I understand that I may review this privacy notice at any time prior to signing this form.

I understand that over time Delta Chiropractic Associates Inc.'s privacy practices may change in accordance with law and that if I wish to obtain a copy of the notice as revised, I can call Delta Chiropractic Associates Inc. to request such copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations, and that I can also revoke this Consent in, but only to the extent that Delta Chiropractic Associates Inc. has not taken action in reliance thereon and also provided that I do so in writing.

I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing.

_____

Patient Name (please print)

_____ _____

Signature of Patient Date

_____

Signature of Patient Representative
(Required if patient is a minor or adult unable to sign this form)

_____

Relationship to Patient

For Office Use Only

If unable to obtain acknowledgement from patient, describe the good faith effort to obtain patient's signature on this form:

_____

If known, provide reason patient would not sign this form:

_____

Signature of Clinic Representative:_____

Print Name: _____