

**PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION**

With my consent, Dr. Alan Schwartz or Winter Springs Chiropractic Center, PA, may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to Winter Springs Chiropractic Center's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Winter Springs Chiropractic Center, PA or Dr. Alan Schwartz reserves the right to revise its' Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Alan Schwartz, Winter Springs Chiropractic Center, PA Privacy Officer, 1340 Tuskawilla Rd. Suite 112, Winter Springs, FL 32708.

With my consent, Dr. Alan Schwartz or Winter Springs Chiropractic Center, PA may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care.

With my consent, Dr. Alan Schwartz or Winter Springs Chiropractic Center, PA, may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders, and patient statements as long as they are marked Personal and Confidential.

I have the right to request that Dr. Alan Schwartz or Winter Springs Chiropractic Center, PA, restricts how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, is bound by this agreement.

By signing this form, I am consenting to Dr. Alan Schwartz or Winter Springs Chiropractic Center, PA's, use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Dr. Alan Schwartz or Winter Springs Chiropractic Center, PA, may decline to provide treatment to me.

Signature of patient or legal guardian

Patient's name (please print)

Date