Consent for Purposes of Treatment, Payment, and Healthcare Operations

I consent to the use or disclosure of my protected health information by **Love Chiropractic, Inc.** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **Love Chiropractic, Inc.**. I understand that diagnosis or treatment of me by **Dr. David B. Love, D.C.** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. **Love Chiropractic, Inc.** is no required to agree to the restrictions that I may request. However, if **Love Chiropractic, Inc.** agrees to a restriction that I request, the restriction is binding on **Love Chiropractic, Inc.** and **Dr. David B. Love, D.C**.

I have the right to revoke this consent, in writing, at any time, except to the extent that **Dr. David B. Love, D.C.** or **Love Chiropractic, Inc.** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information my identify me.

I understand I have a right to review the Notice of Privacy Practices of **Love Chiropractic, Inc.** prior to signing this document. **Love Chiropractic, Inc.**'s Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosure of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of **Love Chiropractic, Inc.**. The Notice of Privacy Practices for **Love Chiropractic, Inc.** is also provided at **1220 41st Ave., Suite I, Capitola, CA 95010**. This Notice of Privacy Practices also describes my right and **Love Chiropractic, Inc.**'s duties with respect to my protected heath information.

Love Chiropractic, Inc. 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 of **Love Chiropractic, Inc.** and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

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Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of personal Representative's Authority