BLUE MOUNTAIN CHIROPRACTIC CENTER
3585 Crompond Road
Cortlandt Manor, NY 10567

PATIENT CONSENT FOR USEAND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

____, hereby states that by signing this Consent, I acknowledge and agree with the following:

1. BLUE MOUNTAIN CHIROPRACTIC CENTER's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for BLUE MOUNTAIN CHIROPRACTIC CENTER to provide treatment to me, and also necessary for BLUE MOUNTAIN CHIROPRACTIC CENTER to obtain payment for that treatment and to carry out health care operations. BLUE MOUNTAIN CHIROPRACTIC CENTER explained to me that the Privacy Notice will be available to me in the future at my request. BLUE MOUNTAIN CHIROPRACTIC CENTER has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2. BLUE MOUNTAIN CHIROPRACTIC CENTER reserves the right to change it's privacy practices that are described in it's Privacy notice, in accordance with applicable law.

3. I understand that, and consent to, the following appointment reminders that will be used by BLUE MOUNTAIN CHIROPRACTIC CENTER: a) a postcard mailed to me to the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.

4. BLUE MOUNTAIN CHIROPRACTIC CENTER may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for BLUE MOUNTAIN CHIROPRACTIC CENTER to treat me and obtain payment for that treatment, and as necessary for BLUE MOUNTAIN CHIROPRACTIC CENTER to conduct it's specific health care operations.

5. I understand that I have the right to request that BLUE MOUNTAIN CHIROPRACTIC CENTER restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, BLUE MOUNTAIN CHIROPRACTIC CENTER is not required to agree to any restrictions that I have requested. If BLUE MOUNTAIN CHIROPRACTIC CENTER agrees to a requested restriction, then the restriction is binding on the Practice.

6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that BLUE MOUNTAIN CHIROPRACTIC CENTER has already taken action in reliance on this consent.

7. I understand that if I revoke this consent at any time, BLUE MOUNTAIN CHIROPRACTIC CENTER has the right to refuse to treat me.

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then BLUE MOUNTAIN CHIROPRACTIC CENTER will not treat me.

I have read and understand the foregoing notice, and all my questions have been answered to my full satisfaction in a way I can understand.

____________________________ ______________________________
Name of Individual (Printed) Signature of Individual

____
Signature of Legal Representative Relationship (e.g. Attorney-in Fact, Guardian, Parent is a minor)

Date Signed _____/_____/_____ Witness ____