PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION

Johnson Chiropractic and Rehabilitation, P.A. obtains and maintains health information relating to my past, present, future physical or mental condition, provision of health care, or payment for health care, referred to as "Protected Health Information." This Protected Health Information may be used or disclosed by the P.A. for the purposes of treatment, payment, or health care operations, including, but not limited to:

* Planning for my care and treatment
* Informing my primary care doctor about my treatment
* Calling me with appointments reminders and lab results
* Submitting a claim to my insurer or health plan
* Converting my medical record to an electronic record
* Assessing the quality of care provided to me

The P.A.'s Notice of Privacy Practices contains a more complete description of how my Protected Health Information may be used and disclosed and how I can obtain access to this information. I understand that the P.A. reserves the right to changes it's Notice and practices, and I can request a copy of it's current Notice.

I understand that I have the right to request restrictions as to how my Protected Health Information may be used or disclosed by the P.A. The P.A. is not required to agree to my request, but if the P.A. does agree, the requested restrictions will be binding on the P.A.

I further understand that, at any time, I may revoke this consent in writing, except to the extent that the P.A. has already taken action in reliance on it.

By signing this form below, I consent to the P.A.'s use and disclosure of my Protected Health Information for the purposes of treatment, payment, and/or health care operations. I also acknowledge that I have received a copy of the Notice of Privacy Practices of the P.A.

Signature of Patient or Legal Representative   Witness

Date

If executed by Legal Representative, please describe relationship to patient: