CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I acknowledge that **RAUCH CHIROPRACTIC LIFE CENTER'S** "Notice of Privacy Practices" has been provided to me.

I understand I have a right to review **RAUCH CHIROPRACTIC LIFE CENTER'S** notice of Privacy Practices prior to signing this document. **RAUCH CHIROPRACTIC LIFE CENTER'S** notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of **RAUCH CHIROPRACTIC LIFE CENTER**. The notice of Privacy Practices for **RAUCH CHIROPRACTIC LIFE CENTER** is also provided on request at the main administration desk of this practice and on **RAUCH CHIROPRACTIC LIFE CENTER'S** website at www.rauchchiropractic.com. This notice of Privacy Practices also describes my rights and **RAUCH CHIROPRACTIC LIFE CENTER'S** duties with respect to my protected health information.

RAUCH CHIROPRACTIC LIFE CENTER 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 accessing **RAUCH CHIROPRACTIC LIFE CENTER'S** website, calling the office and requesting a revised copy be sent in the mail, or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative

_____

Description of Person Representative's Authority