Penn Chiropractic Centre

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Consent for Purpose of Treatment, Payment and Healthcare Operations

I acknowledge that Dr. Randolph J. Penn's " Notice of Privacy Practices" has been provided to me.

I understand I have the right to review Dr. Randolph J. Penn's " Notice of Privacy Practices" prior to signing this document. Dr. Penn'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 operation of Randolph J. Penn , D.C. The Notice of Privacy Practices for Randolph . Penn, D.C. is also provided on request at the main administration desk of his practice. This Notice of Privacy Practices also describes my rights and Dr. Pen's duties with respect to my protected health information.

Randolph J. Penn, D. C. 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 and request 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 Personal Representative's Authority