LIVINGSTON CHIROPRACTIC CLINIC
5889 Whitmore Lake Road #3 ~ Brighton, MI 48116 ~ 810-227-7799
Giulio J. Cogo, D.C. and Jeffrey D. Ewing, D.C.

Consent for Purposes of Treatment, Payment and Healthcare PRIVACY PRACTICES

I acknowledge that Livingston Chiropractic Clinic's "Notice of Privacy Practices" has been made available to me.

I understand I have a right to review the "Notice of Privacy Practices" prior to signing this document. The "Notice of Privacy Practices" describes the types of uses and disclosures of my protected health information and the policies and procedures of confidentiality that will occur in my treatment, payment of my bills or in the performance of healthcare operations of Livingston Chiropractic Clinic. The "Notice of Privacy Practices" for Livingston Chiropractic Clinic is also provided on request at the main administration desk of this office. This "Notice of Privacy Practices" also describes my rights and Livingston Chiropractic Clinic's duties with respect to my protected health information and patient confidentiality.

Livingston Chiropractic Clinic reserves the right to change the privacy practices that are described in the "Notice of Privacy Practices." I may obtain a copy of the revised notice by calling the office and requesting a copy be sent to me by mail or by asking for one at the time of my next appointment.

I give permission for Dr. Giulio J. Cogo, Dr. Jeffrey D. Ewing, and/or members of their staff to discuss my

☐ Care / Condition / Treatment ☐ Financial Statements with the following persons.

Name	**Relationship**
_____	_____
_____	_____

☐ I do not wish any of my information discussed with anyone but myself.

I understand the above permissions will remain in effect until such time as they are revoked in writing. A new authorization, when completed, will replace any older authorizations.

_____ _____
Signature or Patient or Personal Representative Date

_____
Printed Name of Patient or Personal Representative

_____
Relationship to Patient