Patient Consent for Use and Disclosure
Of Protected Health Information

David B. Mankowitz D.C., P.A.

I hereby give my consent for **David B. Mankowitz DC, PA** (hereinafter referred to as the "Practice") to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

The Practice's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. The Practice reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to

David B. Mankowitz DC, PA, our Privacy Officer, at the following address:
4970 Fruitville RD., Sarasota, FL 34232

With this consent, the Practice may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, the Practice may mail to my home or other alternate location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, the Practice may e-mail to my home or alternate location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that the Practice restrict how it uses or discloses my PHI to carry out TPO. However, the Practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. With this consent I hereby give David B. Mankowitz D.C.,P.A. permission to post my name on the referral board in acknowledgment for the referral of new patients and also to use my name, picture and testimonials.

By signing this form, I am consenting to the Practice's use and disclosure of my PHI to carry out TPO. I acknowledge that I have read a copy of David B. Mankowitz D.C.,P.A's Notice of patient privacy practices.
I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, the Practice may decline to provide treatment to me.

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Signature of Patient or Legal Guardian

__________________________________ _________________
Patient's Name Date

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Print Name of Patient or Legal Guardian