



BOURREE CHIROPRACTIC AND MASSAGE  
 KIRKLAND PROFESSIONAL CENTER  
 433 STATE STREET SUITE 6  
 KIRKLAND, WA 98033

**Consent for Purposes of Treatment, Payment and Health Care Operations**

I consent to the use or disclosure of my protected health information by **Bourree Chiropractic and Massage** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **Bourree Chiropractic and Massage**.

I understand that diagnosis or treatment of me by **Dr. David Bourree** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. **Bourree Chiropractic and Massage** is not required to agree to the restrictions that I may request. However, if **Bourree Chiropractic and Massage** agrees to a restriction that I request, the restriction is binding on **Bourree Chiropractic and Massage** and **Dr. David Bourree**.

I have the right to revoke this consent in writing at any time, except to the extent that **Dr. David Bourree** or **Bourree Chiropractic and Massage** has taken action in reliance on this consent.

My "protected health information" means health information including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review **Bourree Chiropractic and Massage's** Notice of Privacy Practices prior to signing this document.

**Bourree Chiropractic and Massage'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 **Bourree Chiropractic and Massage**.

The Notice of Privacy Practices for Dr. David Bourree is also provided at the front desk of **Bourree Chiropractic and Massage**.

This Notice of Privacy Practices also describes my rights and the duties of **Dr. David Bourree** with respect to my protected health information.

**Bourree Chiropractic and Massage** 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 requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

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Signature of Patient or Personal Representative

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Name of Patient or Personal Representative

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Date

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Description of Personal Representative's Authority

With whom may we discuss your healthcare and appointments? \_\_\_\_\_

How may we leave messages for you (phone number for voicemail)? \_\_\_\_\_