Patient Consent regarding Protected Health Information
Manuel L. Mateus, D.C.

Release of Information

By signing this form, you are granting consent to Dr. Manuel L. Mateus, D.C. and his office to use and disclose your protected health information for the purposes of treatment, payment, and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full. You have a right to a copy of our Notice of Privacy Practices if you so desire.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephoning our office. You have a right to request us to restrict how we use and disclose your protected health information for purposes of treatment, payment, or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have a right to revoke this consent in writing, except to the extent we have already used or disclosed your protected health information in reliance on your consent.

Consent for Treatment

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician, and it is the responsibility of the staff to carry out the instructions of such physician(s). I have been informed of your privacy practices and consent to treatment in your office under those conditions.

Medicare & Medicaid Consent to Release Information

I certify that the information given by me in applying for payment under Title XVIII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration, its intermediary carriers, and any secondary payers, any information needed for this or a related Medicare or Medicaid claim.

______________________________ ______________
Patient Name (print or type) Date

______________________________ ______________
Signature of Patient or other responsible party Relationship to patient

____
Your email address

Optional

The following persons are authorized to receive information about my condition.

______________	______________	______________
Name	Name	Name
______________	______________	______________
Relationship	Relationship	Relationship

04/03/2011