MOBILE CHIROPRACTIC CARE OF NJ, LLC.

EXCLUSIONS FROM PRIVACY POLICY

As part of the Privacy Act, you do have the right to restrict access to your medical information. This office will assume you have no restrictions that you wish to place on this information. You may ask us not to use or disclose certain parts of your protected health information for the purpose of treatment, payment or health care operations. If you elected to restrict any information that may hinder in any way my ability to get reimbursed for services rendered, and then the full amount of the service will be immediately due. You may also request that I do not disclose your health information to family or friends who may be involved in your are or for notification purposes as described in the Privacy Notice. Your request state the specific restriction requested and to whom you want the restriction to apply. I am not required to agree to a restriction that you may request. I will notify you if I deny your request to a restriction. If I do agree to the requested restriction, I may not use or disclose your protected health information in violation of the restriction unless it is needed to provide emergency treatment. Under certain circumstances I may terminate our agreement to a restriction. You may request a restriction by contacting the Privacy Officer or by listing the restriction below.

If no boxes are checked, or any organizations are listed, I will have the full right to disclose the information in the normal manner of doing a medical practice.

Please only check boxes you DO NOT wish I release information to reference your condition.

Family Members (Immediate or significant other) _____

Insurance Companies (not related to collection of payment) _____

Lawyers _____

Place of Work _____

School _____

Sports, Teams (Coaches, Trainers, Managers) _____

Military _____

Acknowledgment of Receipt of Notice of Privacy Practices

I _____acknowledge that I have received a copy of Mobile Chiropractic Care of NJ, LLC's Notice of Privacy Practices. This notice describes how this unit may use and disclose my protected health information, certain restrictions on the use and disclosure of my health care information and rights I may have regarding my protected health information.

_____

(Signature of Patient or Personal Representative) Date

_____

(Relationship to Patient)