



CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I acknowledge that Eisman Clinic's "Notice of Privacy Practices" has been provided to me.

I understand I have a right to review Eisman Clinic's 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 that will occur in my treatment, payment of my bills or in the performance of health care operations of Eisman Clinic.

The Notice of Privacy Practices for Eisman Clinic is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Eisman Clinic's duties with respect to my protected health information.

Eisman Clinic reserves the right to change the privacy practices that are described in the Notice of Privacy Practice. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, ask for one at the time of my next appointment or accessing Eisman Clinic.

I have the right to revoke this consent, in writing, except to the extent that Eisman Clinic has taken action in reliance on this consent.

PATIENT ACKNOWLEDGEMENT

By subscribing my name below, I acknowledge receipt of a copy of this notice, and my understanding and my agreement to its terms.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority

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Detroit, MI 48235

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