Lucinda P. Burke, D.C., P.C.

44 N. Washington St.
Oxford, MI 48371

Consent for Purposes of Treatment,

Payment and Healthcare Operations

I understand I have a right to review Dr. Lucinda P. Burke, D.C., P.C.'s Notice of Privacy Practices prior to signing this document. Dr. Lucinda P. Burke'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 Lucinda P. Burke, D.C., P.C. The Notice of Privacy Practices is also provided upon request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Dr. Lucinda P. Burke's duties with respect to my protected health information.

Dr. Lucinda P. Burke, D.C., P.C. 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 by asking for one at the time of my next appointment.

Signature of Patient or Personal Representative: ______________________________

Printed Name of Patient or Personal Representative: ___________________________

Relationship to Patient: ____

Date: _____________________________