CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I acknowledge that Brighton Alternative Solutions "Notice of Privacy Practices" has been proved to me. I understand I have a right to review Brighton Alternative Solutions 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 operation of Brighton Alternative Solutions The Notice of Privacy Practices for Brighton Alternative Solutions is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Brighton Alternative Solutions duties with respect to my protected health information.

Brighton Alternative Solutions 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 call the office and requesting a revised copy be sent in the mail, ask for one at the time of my next appointment.

I have the right to revoke this consent, in writing, except to the extent that Brighton Alternative Solutions 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