Acknowledgment of Receipt of Privacy Notice

I have been presented with The Training Room, LLC's **Notice of Privacy Practices**, detailing how my information may be used and disclosed as permitted under federal and state law (upon request a full copy will be present for your records). I understand the contents of the notice, and I request the following restriction(s) concerning the use of my personal medical information:

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Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

____ ____________________

Signature of Patient, Parent, Guardian Date

Consent for Treatment

TREATMENT AUTHORIZATION: I, the below named patient, do hereby give The Training Room, LLC consent for medical treatment.

____ ____________________

Signature of Patient, Parent, Guardian Date