D·R·E·A·M®
wellness

Authorization to Use or Disclose Protected Health Information

Your authorization is requested for purposes of delivering your care in an open-adjusting or open-door adjusting environment, for contact regarding chiropractic care, related health services and/or related health products and for appointment reminders and scheduling related matters as described in the office's privacy policy.

In the course of your care in either of these environments routine details of your condition and care may be disclosed to other patients or staff in the approximate vicinity of where your care is being delivered. We cannot assure that any of the details of your care will be addressed and considered as confidential by other patients. It is our desire to use your name, address, e-mail and/or telephone number for the purpose of contacting you to advise you about health related meetings, workshops, products and scheduling related matters.

We are requesting your authorization in this regard to assure that you are fully informed and in agreement with the method and circumstances in which we deliver chiropractic care. Your care will not be conditioned on your agreement to this authorization. You have the right not to sign this authorization and you also have the right to revoke this authorization at a later date if that is your wish. If you wish to revoke this authorization at some time in the future please advise us accordingly in writing.

If you agree to this authorization a copy will be maintained by this office and a copy will be provided to you.

Thank you for your cooperation and understanding.

Name:

_____

Signed Date

If you are a minor or if you are being represented by another party please provide the appropriate person's:

Name

_____

Signature Date

Relationship to the patient

This authorization expires on: April 1, 2010