HEALTH CARE AUTHORIZATION FORM

PATIENTS NAME: (please print) _____ Date: _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES QUAIL VALLEY CHIROPRACTIC, M. JEROME LEWIS, D.C. TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING: IF YOU **DO NOT** GIVE PERMISSION MARK "NO", OTHERWISE MARK "YES".

YES NO Permission to use my name, address, phone #,and clinical records to contact me with birthday cards, holiday related cards, newsletters, thank you cards, office hour changes, or other health related info.

YES NO Permission to treat me in an open or partially open room where other patients are being treated(i.e. traction). I am aware that other persons may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time, a private room will be provided.

YES NO Permission to call me or leave messages at my home or my job regarding missed appointments, schedule changes, insurance issues.

YES NO Permission to release medical info. or insurance info. for scheduling diagnostic testing (i.e. MRI, NCV) or to another medical specialist.

RIGHT TO REVOKE AUTHORIZATION:

You may revoke this authorization by mailing or hand delivering a written notice to the Privacy Official of Quail Valley Chiropractic. The written notice must have your full name, SS#, and date of birth, and your signature. The revocation is not effective until it is received by the Privacy Official.

You have the right to refuse to sign this authorization without being denied chiropractic care by Quail Valley Chiropractic.

You have the right to inspect or copy the Personal Health Information (PHI) to be used or disclosed. You may have a copy of this signed form for your records.

My signature indicates that I have read and understand this authorization form.

Signature:_____