HEALTH CARE AUTHORIZATION FORM

Patient’s Name :

Date of Birth :

THE PATIENT IDENTIFIED ABOVE AUTHORIZES **MYERS CHIROPACTIC** TO USE AND/ OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

**WRITTEN COMMUNICATION**

I give permission to **MYERS CHIROPRACTIC** to use my address and clinical records to contact me with birthday cards, holiday related cards, newsletters and information about treatment alternatives or other health related information.

**ORAL COMUNICATION**

I give permission to **MYERS CHIROPRACTIC** to contact me by phone in the following manner:

Home Telephone

OK to leave message with detailed information

Leave message with call-back number ONLY

Work Telephone

OK to leave message with detailed information

Leave message with call-back number ONLY

By signing this form you are giving MYERS CHIROPRACTIC permission to use and disclose your protected health information in accordance with the directives listed above.

Patient Signature Date