ANTHONY WAYNE
COMMUNITY CHIROPRACTIC

HEALTH CARE AUTHORIZATION FORM

Client Name _____

THE PERSON(S) IDENTIFIED ABOVE AUTHORIZES **ANTHONY WAYNE COMMUNITY CHIROPRACTIC** TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

I give permission to Anthony Wayne Community Chiropractic to use my address, phone number, and clinical records to contact me with appointment reminders, missed appointment notifications, email newsletters, related cards (welcome, thank you, congratulatory, sympathy, etc.) or other health related information. I also give my permission to use my name and photos in testimonial format (if applicable). The display of any name or photo would ONLY be done after receiving verbal authorization.

If Anthony Wayne Community Chiropractic contacts me by phone, I give them permission to leave a phone message on my answering machine or with a family member taking a message personally or by voicemail.

I give Dr. Michael Hollerbach permission to adjust me in a semi-open room where other members are also being treated. I am aware that other members in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations.

I give Dr. Michael Hollerbach permission to use my first name and overall outcome (if applicable) when relaying experience and educational information to another patient.

By signing this form, I am giving Anthony Wayne Community Chiropractic permission to use and disclose my protected health information in accordance with the directives listed above.

This authorization shall remain in effect unless revoked in writing by the member.

Client Signature (or Guardian) _____ Date_____

Dr. Michael Hollerbach DC

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