



SCARBOROUGH
FAMILY CHIROPRACTIC

Appointment Reminders and Health Care Information Authorization

At times our office may need to contact you with appointment reminders, information about treatment or other health related information. By signing below, you are giving us authorization to contact you with these reminders / information and understand that...

I may be contacted by: phone at home or work, mobile phone, e-mail, postal mail.

Messages may be left: on answering machine / voicemail at home, work, and on mobile phone.

Or individuals answering my phone at home, or work.

Also: send personalized cards (birthday/holiday/special events), office newsletter, special office announcements or appointment reminders, correspondence letters pertaining to my care, with your permission use your name and/or photograph for office events / testimonials / bulletin board, your chart will be placed outside the door of the adjusting room in a folder bin, if you were a previous patient of the month your name will appear in the newsletter of that quarter, with your permission use your chiropractic story in our testimonial book.

Please place a line through any method you REFUSE to, and place your initials there.

Information that we use or disclose based on this authorization may be subject to re-disclose by anyone that has access to the reminder or information and may no longer be protected by the federal privacy rules.

You may restrict the individuals or organizations to which your health care information is released, or revoke your authorization at any time; however the revocation must be in writing and will become effective once we receive the revocation. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

You have the right to refuse any part of this authorization without affecting your treatment or the methods used to obtain reimbursement for your care. You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (§ 164.524).

I authorize the use or disclosure of my health information as described above. This notice is effective as of the date below and expires seven years from the date I last received services in this office.

Patient Name Printed

Date

Patient Signature

Authorized Provider Rep. (SFC)

Personal Rep Printed

Personal Rep Signature

Description of personal representative's authority to act for the patient.