

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Name: _____
Address: _____
Home Phone #: _____ Cell: _____ Work: _____
D.O.B.: _____ Social Security #: _____ E Mail: _____

INDIVIDUAL'S RIGHTS RELATING TO THIS AUTHORIZATION

By signing this form, you will authorize Shoemaker Chiropractic Center to release Protected Health Information, to carry out treatment, payment activities and healthcare operations.

I understand that Shoemaker Chiropractic Center provided me with a copy of the NOTICE OF PRIVACY PRACTICES. I understand that I am under no obligation to sign this form, and that the practice may not condition my treatment, payment or eligibility for benefits on my decision to sign this form. I understand that I may revoke this Authorization by notifying the practice in writing. This Authorization is valid until it is revoked by either party.

I have had an opportunity to review and understand the content of this Authorization form and the Notice Of Privacy Practices. By signing this authorization, I am confirming that it accurately reflects my wishes.

INDIVIDUAL SIGNATURE: _____
PERSONAL REPRESENTATIVE SIGNATURE: _____
RELATIONSHIP TO
PATIENT: _____
DATE: _____

INFORMED CONSENT

After reviewing your health history, the Doctor will examine you and may require other diagnostic tests such as x rays, MRI or lab tests to make an accurate diagnosis and treatment plan. The Doctor will select a treatment plan which best suits your needs. You will be informed of alternative treatments available to you. Occasionally, the plan may have to be altered during treatment, due to unexpected changes.

At this time, we would like to inform you of the risks that may occur from Chiropractic treatment. They are as follows: muscle soreness and irritation, headache, pain, muscle spasm and stiffness. In rare instances, dizziness and/or nausea may occur.

I certify the information I provided for the health history is true and factual to the best of my knowledge. I understand the office policy and the risks associated with chiropractic treatment, which were supplied in the statement above, and hereby give my consent.

PATIENT SIGNATURE: _____
DATE: _____
PERSONAL REPRESENTATIVE SIGNATURE: _____