

# STIRES CHIROPRACTIC CENTER HEALTH CARE AUTHORIZATION FORM

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

THE PATIENT IDENTIFIED ABOVE AUTHORIZES STIRES CHIROPRACTIC CENTER TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

## SPECIFIC AUTHORIZATIONS

- I give permission to Stires Chiropractic Center to use my address, phone number, email address and clinical records to contact me with birthday cards, holiday related cards, reminder cards, welcome and referral thank you cards, appointment reminders, newsletters and information about treatment alternatives or other health related information.
- I give Stires Chiropractic Center permission to treat me in an open room where other patients are also being treated. I am aware that other persons 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 Stires Chiropractic Center permission to use my name in their office, website, or Facebook with any testimonial I may write or record for their office.
- I give Stires Chiropractic Center permission to use any picture taken by Stires Chiropractic Center staff on their website or Facebook.
- By signing this form you are giving Stires Chiropractic Center permission to use and disclose your protected health information in accordance with the directives listed above.

## **EXPIRATION**

The Authorization shall expire on the following date: \_\_\_\_\_