Allen Chiropractic Care, Inc.

The doctor's choice for advanced pain relief.

Disclosure of Medical Information: Your medical information and communication of that information is essential to your care. We prefer to speak directly with each patient but we understand that other individuals or family members may have knowledge of and be assisting in your care. Please list the individuals who we are authorized to discuss your care with. (NOTE: we cannot discuss your care with others, including spouses or other family members living with you, unless they are listed below.

Name of Person	Relationship to Patient
____________________	____________________
____________________	____________________

Confidential Communication: Communication between this practice and you, the patient, is critical to your health. Please list the phone number(s) where we can reach you.

( ) Home:____________________ ( ) Work:____________________

( ) Cell Phone:____________________ ( ) Other:____________________

If we are unsuccessful at reaching you at the above phone numbers, please list others who we can contact to get a message to you to call our office.

Name of Person	Phone Number	Relationship to Patient
____________________	______________	______________
____________________	______________	______________

Messages: A request for return calls may be left on the following answering machine or voice mail

( ) At Home ( ) At Work ( ) On my cell phone ( ) I do not authorize

Signatures: I hereby authorize the use or disclosure of the personal health information as described above.

Patient/Personal Representative Signature:____________________Date:______________

PRINT Name of Personal Representative:____

Relationship of Representative to Patient:____

Patient Signature____Date:______________