Patient Authorization for appointment reminders and scheduling related matters as well as chiropractic care, related services and/or related health products and information.

It is our desire for our staff to use your name, address and/or telephone number for the purpose of contacting you to remind you about scheduled appointments and re-evaluations or other appointment related issues, as well as to advise you about health-related meetings, workshops, products and information.

The use of this information is intended to make your experience with our office more efficient, productive, and to further enhance your access to quality health care. If you choose not to authorize this information use, your decision will have no adverse effect on your care from the date of this notice or on your relationship with our staff.

Your signature indicates your authorization of this activity.

_____	_____	_____
Name (Print)	**Signature**	**Date**

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.