IMBROGNO CHIROPRACTIC & HEALING ARTS CENTER **973-783-0444**

PROTECTED HEALTH INFORMATION (PHI) USES AND DISCLOSURES WHICH REQUIRE AUTHORIZATION

APPOINTMENT REMINDERS

As a courtesy to our patients, you may receive reminder calls about upcoming appointments, or follow up calls to check on condition status.

I may be contacted at home:	( ) yes	( ) no
I may be contacted at work:	( ) yes	( ) no
I may be contacted on cell phone:	( ) yes	( ) no
If I am personally unavailable, a message may be left for me:	( ) yes	( ) no

MAILING INFORMATION

Our office may mail you information regarding your account status or billing information.

I authorize receipt of information about my health care/account status/billing info by mail: ( ) yes ( ) no

E-MAIL

May we send you e-mail pertaining to appointment reminders, special announcements, office events, and birthday and general holiday occasions? ( ) yes ( ) no

e-mail address: _____

RELEASE OF INFORMATION

Information about my case may be released to:

Name of Spouse/Significant Other: _____

Name of Family Member(s): _____ Relationship to you? _____

Name of Physician(s): _____

Name of other health Care Provider(s): _____

Your signature indicates your authorization of all information above and that I have reviewed the Privacy Practice Notice from Imbrogno Chiropractic Center, P.A. I may have a copy of this notice upon my request.

_____ _____ _____

Name (printed) Signature Date

If you are a minor, or if you are being represented by another party:

_____ _____

Personal Representative (Printed) Personal Representative Signature Date

You may revoke this authorization at any time by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable time for the change in our procedures to be completed.

Revised January 27, 2015