COLEMAN FAMILY CHIROPRACTIC ~ THE PG WELLNESS INSTITUTE
~ NATURAL HEALING FOR A LIFETIME OF WELLNESS ~
1219 FOREST AVENUE, SUITE I, PACIFIC GROVE, CALIFORNIA 93950
O: 831.375.0270 ~ F: 831.375.0279 ~ WWW.COLEMANFAMILYCHIROPRACTIC.COM

HEALTH CARE AUTHORIZATION

Patient's Name: _____ Date of Birth: _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES COLEMAN CHIROPRACTIC TO USE AND OR DISCLOSE THE PROTECTED HEALTH INFORMATION (PHI) IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

- ❑ I give permission to Coleman Family Chiropractic (CFC) to use my address, phone number and clinical records to contact with appointment reminders, missed appointment notification, birthday cards, holiday related cards, informative newsletters about treatment alternatives or other health related information.
- ❑ If CFC contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.
- ❑ I give CFC 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 Dr. Coleman at any time in private, Dr. Coleman will provide a room for these conversations.
- ❑ By signing this form you are giving CFC permission to use and disclose your protected health information in accordance with the directives listed above.

RIGHT TO REVOKE THE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of CFC. The written notice must contain the following information:

- Your name, your social security number and your date of birth;
- A clear statement of your intent to revoke this AUTHORIZATION; the date of your request; and
- Your signature (for confirmation)

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by CFC for its own use/disclosure of PHI. (*Minimum necessary standards apply.)*
You have the right to refuse to sign this AUTHORIZATION. However, if you refuse to sign this AUTHORIZATION Coleman Chiropractic will not refuse to provide treatment. You have the right to inspect or copy the PHI to be used/disclosed.

** A COPY OF THE SIGNED AUTHORIZATION WILL PROVIDED TO YOU **

Name of Patient (*print)*: _____ Date: _____

Signature of Patient: _____ Date: _____

Signature of Personal Representative: _____

Description of Representative's Authority To Act for Patient: _____

Patient File #: _____