

REED CHIROPRACTIC HEALTH CARE AUTHORIZATION FORM

Patient's Name _____ Date _____

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

SPECIFIC AUTHORIZATIONS

- I give permission to Reed Chiropractic to use my address, phone number and clinical records to contact me with birthday cards, holiday related cards and information about treatment alternatives or other health related information.
- By signing this form you are giving Reed Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above.

I am aware of Dr. David T. Reed's Notice of Privacy Practices. A full copy is available at my request.

Signature _____ Date _____