**HEALTH CARE AUTHORIZATION FORM**

THE PATIENT IDENTIFIED ABOVE AUTHORIZES Wards Corner-Chiropractic, Inc. TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

I give Wards Corner Chiropractic, Inc. 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 doctor at any time in private; the doctor will provide a room for these conversations.

- I give Wards Corner Chiropractic, Inc. permission to combine any mailings with my spouse. I, also, give my spouse permission to call for and cancel my appointments.

- I give permission to Wards Corner Chiropractic, Inc. to use my email address for the Wards Corner Chiropractic newsletter, informing me of heath related information, news happening in our practice and treatment alternatives.

- I give Wards Corner Chiropractic, Inc. permission to display any pictures that I *give them* of myself or my children on the picture wall.

- You have the right to revoke this authorization, in writing, at any time. However, your written request to revoke this authorization is not effective for services already provided.

You may revoke this authorization by mailing or hand delivering a written notice to the Privacy Official of Wards Comer Chiropractic, Inc. The written notice must contain the following information: Your name, Social Security number, date of birth, a clear statement of your intent to revoke this authorization, the date of your request, and your signature. The revocation is not effective-until it is received by the Privacy Officer.

A copy of the signed authorization will be provided to you upon request.

This Authorization expires seven years after the patient's last date of service.

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Print Patient’s Name

_____ _____

Signature of Patient/Guardian Date