

Larson Chiropractic, P.C.
Larson Chiropractic & Wellness, P.C.
PHI Use and Disclosure Authorization

If you wish to have your medical or billing information released to family members you must fill out the information and sign below. **We have permission to** (please check all that apply):

- Leave messages on home phone or with household members about appointments, and test results.
- Leave messages on work phone about appointments, and test results.
- Leave messages on cell phone about appointments, and test results.
- Email appointment reminders
- Confirm appointments by phone or text

This authorization is effective through (check one):

- ____ / ____ / ____
- NO EXPIRATION** unless revoked or terminated by the patient or the patient's personal representative.

I hereby authorize the clinic to disclose my individually identifiable health information to the individuals listed below:

1. Name _____ Relationship to Patient _____

Authorization to:

- Disclose treatment plans and test results
- Billing information including statement balances
- Past and future Appointments
- Receive phone messages and/or email regarding appointments or test results
- Other _____

2. Name _____ Relationship to Patient _____

Authorization to:

- Disclose treatment plans and test results
- Billing information including statement balances
- Past and Future Appointments
- Receive Phone Messages or email regarding appointments or test results
- Other _____

I understand that I may revoke this authorization to disclose information at any time by notifying the clinic in writing (*Termination of Disclosure Form* provided upon request). If I choose to do so, I am aware that my revocation will not affect any actions taken by the clinic until the termination request is received in writing and processed.

Authorization to Disclose:

Patient Name (print)

Patient's Date of Birth

Patient Signature

Date

Signature of Personal Representative

Date

Relationship to Patient: _____ Driver's License Number: _____ State _____