Townsend Chiropractic and Wellness Center

Dr. Rick Townsend

I, _____, hereby authorize release of my Protected Health Information for discussion of my care and treatment or payment to the person(s) specified below (45CFR, 164.502(F) & 164.502(G):

Authorized family member or person to receive information for the above named patient's care or payment:

_____	_____	_____
Print Primary Contact	Relationship to Patient	Phone

Others authorized to receive my information (please list names and relationship):

_____	_____	_____
Print Name	Relationship to Patient	Phone

*Note: This form does not give the above referenced persons permission to make health care decisions for the patient. We will not release via the telephone or any other means of communication any information to any friends or family members not listed above unless the patient has an opportunity to object and does not (documented) or if it is reasonable to infer that the patient does not object such as when a patient brings a spouses into the room when treatment is being discussed. Exception: if the release is needed in emergency situations

_____

*If you are in our clinic seeking treatment and a spouse or other family member calls to inquire if you are still there can we say yes or no? Yes_____ No_____

*Leave a message on answering machine? Yes_____ No_____
(Example: May we leave message reminders, scheduling changes or notices that lab results are in on your answering machine? Would this process be acceptable, yes or no?)

*Leave message for patient to return call? Yes_____ No_____
(Example: We may leave a message regarding appointment reminders, scheduling changes or notices that lab results are in with an individual who answers the phone. Would this process be acceptable, yes or no?

*Acknowlegement Statement: I have been offered a copy of the Notice of Privacy Practices and received a copy._____

I have been offered a copy of the Notice of Privacy Practices and declined a copy._____

Patient:_____ Date:_____
Signature

Personal Representative:_____ Relationship to Patient_____
Name Please Print

This form may only be revoked by your signature below:

Patient:_____ Date:_____

Patient Name_____
Social Security_____
Date of Birth_____ Acct#_____