Hansen Chiropractic Wellness Center

Contact Authorization Form

Respect for your privacy is a top concern at our office and often patient will request that we leave detailed voice messages about their healthcare. While we try to accommodate our patients, we also have to adhere to HIPAA regulations. The form below will allow us to leave voice messages at specific telephone numbers or discuss information about you, the patient, and to individual(s) who are non-medical in relation.

Patient Name (Print) _____ Date of Birth _____

Children/Dependent Name(s) _____

_____

Email _____

Hansen Chiropractic can leave voice messages at the numbers you provided below?

☐ Home/Cell Phone ( ) _____ ☐ Work Phone ( ) _____

Please check all that apply.	If you have authorized us to leave a message, please indicate specifics below:
☐ Leave message - appointment date and time	☐ Voicemail / answering machine only
☐ Leave message - lab/test results, other	☐ Whoever answers the phone
☐ Do not leave message of any kind	☐ Only the following individuals: _____ _____ _____

These individual(s) have been selected by the patient listed above as an authorized contact for the specified information.

1.) _____

Authorized Contact Full Name (Print) Telephone Relation

2.) _____

Authorized Contact Full Name (Print) Telephone Relation

Information to Be Released to Contacts:

I authorize my chiropractor and/or their representative to discuss limited protected health information, pertaining to me, to the following individuals(s) who is authorized by me to receive such PHI for the purposes of informing them of my general medical condition and diagnosis for treatment, payment, and other needs related to my healthcare

Please INITIAL by all items or information that can be discussed with the above individual(s):

_____ Medical Information (Any information regarding your health diagnosis and treatment plans, etc.)

_____ Financial Information (Any information regarding your insurance, payment plans, credit & balances, etc.)

_____ Documentation Pick Up. An Authorization to release information signed by the patient will be required. (All individuals who are picking up any documentation must show a form of identification.)

X _____

Patient's Signature/Parent with Legal Custody/Power of Attorney/Guardian (Print) **Date**

- Termination of authorization: This authorization will remain in effect until terminated by me, my legally authorized personal representative or another individual(s) authorized to act on my behalf by court order or law.
- I am responsible for any changes or updates related to the individuals I list on this form as well as the contact information associated with those individuals.
- Right to revoke: I have the right this authorization by submitting a written request.

☐ **I do not want to receive emails**