Hartwell Chiropractic and Wellness Center

Authorization to Release Protected Health Information (PHI)

Patient Name (print): ______________________________ Date of Birth: ________________

*I hereby give my written permission for Hartwell Chiropractic to speak with the following people, (please include full name and relationship) NOT including your physicians.

(If you are choosing not to list anyone, please write NONE on the line below.)

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Regarding (please check all that apply)

☐ Medical information ☐ Appointment scheduling or rescheduling

☐ Billing and insurance ☐ Other____________________

*I DO ☐ I DO NOT ☐ authorize Hartwell Chiropractic to send me emails regarding my care and follow up: Email Address___________________________________

Appointment Reminders:

We are happy to provide appointment reminders as a courtesy for our patients. Please indicate if you would rather receive:

☐ Text Message at this Number: __________________________________

☐ Email at this address: ____

Patient Statements:

☐ I DO give permission for Hartwell Chiropractic to send me bills and statements via email at this address:_____________________________

☐ I DO NOT give permission for Hartwell Chiropractic to send me bills and statements via email. Please send statements here: ____

*I understand Hartwell Chiropractic can only speak with the person(s) I have listed above. I may revoke this permission at any time in person or by written request.

Signature: _____________________________________ Date:______________________

Witness:_______________________________________ Date:______________________

Effective 2/26/19