PREMIER CHIROPRACTIC + PERFORMANCE

Consent for Communication and/or Disclosure

I am requesting the following alternative or limitation relating to any communications concerning me by my healthcare provider.

Do we have your permission to contact you at home, work, or by cell phone: Yes / No

If yes, may we leave the following information on your voicemail or answering machine:

1. Appointment Information: Yes / No
2. Billing Information: Yes / No
3. Medical Information: Yes / No

Also, please accept this as my written consent to share the following information to the additional individual listed below:

Name:_____ Relationship:_____ Phone Number:_____

Appointment: Yes / No Billing: Yes/ No Medical: Yes / No

Name:_____ Relationship:_____ Phone Number:_____

Appointment: Yes / No Billing: Yes/ No Medical: Yes / No

Name:_____ Relationship:_____ Phone Number:_____

Appointment: Yes / No Billing: Yes/ No Medical: Yes / No

Name:_____ Relationship:_____ Phone Number:_____

Appointment: Yes / No Billing: Yes/ No Medical: Yes / No

Patient Name (print):_____

Date:_____

Patient Signature: _____

Date:_____

Witness Name: _____Date:_____

Witness Signature:_____

Date:_____