HEALTH CARE AUTHORIZATION FORM

Patient's Name: _____

SPECIFIC AUTHORIZATIONS

- I give permission to Ryken Chiropractic & Wellness Center to use my address, phone number and clinical records to contact me with birthday cards, holiday related cards and information about treatment alternatives or other health related information. I also authorize the use of my name on the Referral Board and the use of pictures of myself or family members on Our Patient Board.

- I give Ryken Chiropractic & Wellness Center permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations.

- By signing this form you are giving Ryken Chiropractic & Wellness Center permission to use and disclose your protected health information in accordance with the directives listed above.

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your AUTHORIZATION.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of Ryken Chiropractic & Wellness Center. The written notice must contain the following information:

Your name and date of birth;
A clear statement of your intent to revoke this AUTHORIZATION;
The date of your request; and
Your signature.
The revocation is not effective until it is received by the Privacy Official.
You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHOTIZATION, Ryken Chiropractic & Wellness Center will not refuse to provide treatment.

_____
Print Name of Patient

_____
Date Signature of Patient