HIPAA HAPPENINGS

Buller Chiropractic Clinic

Patient Authorization for contact regarding Chiropractic Care, related health services and/or related health products

The federal government has passed new laws that affect how we can contact you if necessary.

Dr. Buller and members of the practice staff may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, information about treatment alternatives or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine or with a family member. By signing this form, you are giving us authorization to contact you with these reminders and information.

The use of this information is intended to make your Experience with our office more efficient, productive and to further enhance your access to quality health care.

If you choose not to authorize use of this information, your decision will have no adverse effect on your care from Dr. Buller, your relationship with our staff, or the effort we make to get your claims paid.

Your signature indicates your authorization of this activity.

_____ _____ _____
Name (Printed) Signature Date

This authorization form was put into effect as of 03/01/2003.This authorization will expire seven years after the date in which you last received services from us, or seven years after the date the authorization was signed. The expiration date of this form will be determined by whichever date is most current.

Your authorization may be revoked at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.

You may inspect or copy the information we use to contact you at anytime. Please indicate if you would like a copy of this form sent to you.

_____ Yes

_____ No

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