McEWEN CHIROPRACTIC CENTER
DR. ALAN F. McEWEN
2386 CLOWER STREET, SUITE G-102
SNELLVILLE, GEORGIA 30078
TELEPHONE (770) 985-9390
FAX (770) 985-7366

HEALTH CARE AUTHORIZATION FORM

PATIENT NAME _____
PATIENT SS# _____ DATE OF BIRTH_____

The patient identified above authorizes McEWEN CHIROPRACTIC CENTER to use and or disclose protected health information in accordance with the following:

SPECIFIC AUTHORIZATIONS

___ I give permission to use my name, address, phone number, e-mail and clinical records to contact me with appointment reminders, missed appointment notification, birthday and holiday related cards, information about treatment alternatives or other health related information.

___ If McEwen Chiropractic Center contacts me by phone I give them permission to leave a message on my answering machine or voice mail.

___ By signing this form you are giving McEwen Chiropractic 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 in effect 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 Dr. Alan McEwen. The written notice must contain the following:

Your name, social security number, 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 in effect until it is received by Dr. McEwen.

McEWEN CHIROPRACTIC CENTER
DR. ALAN F. McEWEN

This authorization is requested by McEwen Chiropractic Center for its own use /disclosure of PHI.

You have the right to refuse to sign this authorization. If you refuse to sign this authorization, McEwen Chiropractic Center will not refuse to provide treatment.

You have the right to inspect or copy the PHI to be used/disclosed.

PRINT NAME OF PATIENT

SIGNATURE OF PATIENT

DATE

SIGNATURE OF PERSONAL REPRESENTATIVE

DESCRIPTION OF REPRESENTATIVE'S AUTHORITY TO ACT FOR PATIENT

E-MAIL ADDRESS