APPOINTMENT REMINDERS AND HEALTH CARE INFORMATION AUTHORIZATION

Dr. Osenbaugh and staff members of Atlas Chiropractic and Nutrition Health Center 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 voice mail. We may send other information by paper mail, electronic mail, fax or other methods. By signing this form, you are giving us authorization to contact you with these reminders and health care information.

You may restrict the individual or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed or delivered in person to our office. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke you authorization. In addition if you were required to give your authorization as condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and ma no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

This notice is effective as of _____. This authorization will expire seven years after the date on which you last received services from us.

_____	_____
Patient Name Printed	**Date**
_____	_____
Patient Signature	**Authorized Provider Representative**
_____	_____
Personal Representative/Relationship to Patient	**Personal Representative Signature**