Pt ID # _____

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Overland Park, KS 66210
info@wholelifedc.com

whole life
CHIROPRACTIC

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Patient Consent Form

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, parents or others to call and request the results of tests and procedures. Under the requirements for H.I.P.A.A., we are not allowed to give this information to anyone without the patient's consent. If you wish to have your test results or information about your care released to family members you must sign this form. Signing this form will only give consent to release information to the family members indicated below. This consent form will not allow Whole Life Chiropractic, PA to release any other information to these family members.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Whole Life Chiropractic, PA to release my results and reports to the following individuals.

1. _____ Relation to Patient: _____
Date:_____

2. _____ Relation to Patient: _____ Date:
_____

PATIENT NAME: _____PATIENT SIGNATURE:
_____

Authorization to Leave Messages with Household Members/Answering Machine

From time to time it is necessary for representatives of Whole Life Chiropractic, PA to leave messages for patients. The purposes of these messages is to remind patients that they have an appointment, to notify the patient that the doctor would like to discuss results, or to ask a patient to call Whole Life Chiropractic, PA regarding an issue or concern. At no time will a representative of Whole Life Chiropractic discuss your medical circumstances or condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Patient Name:_____

Patient Signature:_____ Date:_____