MID ATLANTIC
CHIROPRACTIC CENTER

Communication Authorization

I, _____ give The Mid Atlantic Clinic of Chiropractic permission to discuss the following:

- ☐ Diagnosis, prognosis, and/or treatment information
- ☐ Test results
- ☐ Scheduling information
- ☐ Billing information
- ☐ Other (please specify): _____

With the following people:

_____ Relationship: _____
_____ Relationship: _____
_____ Relationship: _____
_____ Relationship: _____

I also authorize The Mid Atlantic Clinic of Chiropractic to:

- ☐ Leave messages on my home voice mail. The number is ( ) _____
- ☐ Leave messages on my work voice mail. The number is ( ) _____
- ☐ Leave messages on my personal cell phone. The number is ( ) _____
- ☐ Leave messages with my family members residing in my household.
- ☐ Email me at the following address _____

This authorization does not have an expiration date.

Signature: _____ Date: _____

Note: This form must be filled out completely in order for The Mid Atlantic Clinic to ensure the privacy and confidentiality of our patients protected health information.

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Building a Healthier Next Generation One Adjustment at a Time
Simplicity*Sincerity*Excellence