HIPAA COMPLIANCE

Authorized contact(s) and Use of Testimonial

1) I authorize **Vitality Chiropractic** permission to mail letters, call, leave voice/text messages and/or emails regarding previous/future appointments, personal information, health information, account balances, products/services, educational events/seminars, etc. to the following contacts: _____
INITIALS

_____
ADDRESS

(_____)_____ _____@_____
NUMBER **EMAIL**

2) I authorize **Vitality Chiropractic**, in the event I am physically unable: obtain medical records, schedule/reschedule/cancel appointments, update personal/health information and/or pay account balance, permission to allow the following recipients to do so on my behalf: _____
INITIALS

_____ (_____)_____ _____
NAME **NUMBER** **RELATION**

_____ (_____)_____ _____
NAME **NUMBER** **RELATION**

_____ (_____)_____ _____
NAME **NUMBER** **RELATION**

3) I authorize **Vitality Chiropractic** and the following Medical Facilities and/or Doctors permission to exchange any/all medical records regarding my condition: _____
INITIALS

_____ _____ (_____)_____
NAME **STREET ADDRESS** **NUMBER**

_____ _____ (_____)_____
NAME **STREET ADDRESS** **NUMBER**

_____ _____ (_____)_____
NAME **STREET ADDRESS** **NUMBER**

4) In the event I choose to give a patient testimonial (written/photo/video) of my thoughts, feelings, and/or experiences, for the purpose of, but not limited to, the promotion of **Vitality Chiropractic**, Dr. Zebroski and/or staff, I understand it may be used in printed publications, multimedia presentations, on websites and/or in any other distribution media. I agree that I will make no monetary or other claim against **Vitality Chiropractic** for the use of the statement, testimonial/review, video or pictorial representations of me. In addition, I waive any right to inspect or approve the finished product, including written copy or edited video wherein my likeness or my testimonial appears. I release **Vitality Chiropractic** from all claims, demands and causes of action which I, my heirs, representatives, executors, administrators or any other persons, acting on my behalf or on behalf of my estate, have or may have by reason of this authorization. _____
INITIALS

I have read the information above and authorize the initialed sections.

Patient (Print Name):_____

Patient Signature:_____Date:_____

****If patient is under the age of 18 (minor) parent/guardian MUST sign below for consent of treatment.**

Guardian (Print Name):_____Relation:_____

Guardian Signature:_____Date:_____