Arbuckle Chiropractic

Authorization to Release Information via phone/family/friends

Patient Name:____ DOB:__________________

I hereby authorize confidential communications from the physicians or staff of Arbuckle Chiropractic regarding my health care, treatments, appointments, etc… to be received at any of the numbers given below. I authorize the staff to leave messages on the voicemail or with the individual who answers the phone at any of the below numbers:

Home phone:_____________________________ Work phone:____________________________

Cell phone:_______________________________ Other:________________________________

I authorize the following individuals to call the office on my behalf to verify the status of appointments, treatment plan, account information, or anything to do with my chiropractic care. These individuals may also pick up any medicals paperwork and/or x-rays that I have requested:

Name:_______________________________________ Relation:____________________________

Name:_______________________________________ Relation:____________________________

Name:_______________________________________ Relation:____________________________

Name:_______________________________________ Relation:____________________________

I understand this authorization will remain in effect until I revoke the authorization in writing.

Patient Signature:____ Date:__________________

Arbuckle Chiropractic Staff Only:

Documented by:

Initials:______________ Date:_________________________