Dr. Patricia C. O'Brien, PC

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Phone 856.782.7500
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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient's Name: _____

Patient's SS#: _____ Date of Birth: _____

THE PATIENT LISTED ABOVE AUTHORIZES DR. PATRICIA C. O'BRIEN, PC AND OR OTHER LICENSED DOCTORS OF CHIROPRACTIC AND SUPPORT STAFF WHO NOW AND IN THE FUTURE TREAT ME WHILE EMPLOYED BY, WORKING WITH OR SERVING AS BACK-UP FOR DR. PATRICIA C. O'BRIEN, PC TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH BUT NOT LIMITED TO THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

I give permission to Dr. Patricia C. O'Brien, PC

- To use my address and clinical records to contact me with appointment/treatment reminders, missed appointment notifications, birthday cards, holiday related cards, and information about treatment alternatives and other health related information.
- If I am contacted by phone, I give permission to leave a message on my answering machine, voicemail or with whomever my answer the phone numbers I have provided.
- By signing this form I acknowledge that I have read the Notice of Privacy Practices for Protected Health Information as provided. I am giving permission to use or disclose my protected health information in accordance with, but not limited to, the directives listed above.

This authorization expires upon written notification from the above listed patient.

_____ _____
Patient/Guardian Signature Date of Authorization