SHULL CHIROPRACTIC CLINIC, PLLC
Kurt A. Shull, D.C.
1025 South College Street
Winchester, TN 37398
Phone: 931-967-4232 Fax: 931-962-1988

OTHERS INVOLVED IN MY HEALTHCARE

Patient Name:_____
ID Number:_____
You, Kurt A. Shull, D.C., **MAY DISCUSS** all aspects of healthcare with:

_____	_____
Print Name	Relationship
_____	_____
Print Name	Relationship
_____	_____
Print Name	Relationship

As the patient, you may also request that any part of your Private Health Information (PHI) not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician.

You, Kurt A. Shull, D.C., **MAY NOT** discuss any aspect of my health care with the following person/people, unless it is needed to provide emergency treatment.

_____	_____
Print Name	Relationship
_____	_____
Print Name	Relationship
_____	_____
Print Name	Relationship

I, _____, also give permission to Dr. Shull and staff to contact me and leave messages for me to return their call at the following:

A. Place of Employment: Check One: _____Yes _____No Phone #_____
B. Home Land Line: Check One: _____Yes _____No Phone #_____
C. Cell Phone: Check One: _____Yes _____No Phone #_____
D. Email: Check One: _____Yes _____No Email Address:_____

_____	_____
Signature of Patient or Legal Representative	Date

(You have the right to rescind any part of this authorization with written notice)