

### **Specific Authorizations**

1. I give permission to WCWC to use my address, phone number, and records to contact me with birthday cards, holiday related and other cards, referral thank you cards, and information about treatment, newsletters, or other health related information
2. I give permission to WCWC to use my name or my picture on in-office displays for birthday boards, thank you boards, patient testimonies, referral boards, children of chiropractic boards, or other patient recognition presentations.
3. I give WCWC permission to make calls to my home and leave messages on my voicemail or with the attendant about appointment reminder calls or return calls needed.
4. By signing this form, I am giving WCWC permission to use and disclose my protected health information in accordance with the directives listed above.

### **Right To Revoke Authorization**

You have the right to revoke this authorization in writing at any time. However, your written request to revoke this authorization is not effective to the extent that we have provided services or acted in reliance on your authorization. You may revoke this authorization by mailing or hand delivering a written notice to the Privacy Officer of WCWC. The written notice must contain the following information:

Your name, date of birth, the last four digits of your social security number and a clear statement of your intent to revoke this authorization, the date of request, and your signature.

The revocation is not effective until it is received by the Privacy Officer.

This authorization is requested by WCWC for its own use/disclosure of private health information (minimum necessary standards apply).

You have the right to sign this authorization. If you refuse to sign this authorization, WCWC will not refuse to provide treatment. You have the right to inspect or have a copy of the private health information to be used or disclosed.

Print name: \_\_\_\_\_

\_\_\_\_\_  
Signature of patient or legal representative

\_\_\_\_\_  
Date