ARCHER FAMILY WELLNESS CLINIC

Dr. Donna M. Archer

Chiropractic Physician

HEALTHCARE AUTHORIZATION FORM

Patient's Name: ________________________________ Date of Birth: _____________________

THE PATIENTS IDENTIFIED ABOVE AUTHORIZES Donna M. Archer, DC TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:
(Please check specific authorizations)

_____ I give permission to Donna M. Archer, DC to use my address, phone number and clinical records to contact me with appointments reminders, missed appointment notifications, birthday cards, holiday related cards, information about treatment alternatives and / or other health related information. This contact may be in the form of letter, postcard, or E-mail.

_____ If Donna M. Archer, DC contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.

5512 NE 109th Court,
Suite A
Vancouver, WA 98662

Phone: 360-885-4715
Fax: 360-859-3741
E-mail:
Dr.DonnaArcher@comcast.net
Web:
ArcherFamilyWellness.com

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 taken action in reliance on your authorization. A RIGHT TO REVOKE form will be provided upon request. You MUST give this written notice to the Privacy Officer of Donna M. Archer, DC. The written notice must contain the following information:

Your name and date of birth;
A clear statement of your intent to revoke this AUTHORIZATION;
The date of your request; and you signature

The revocation is not effective until it is received by the Privacy Officer of Donna M. Archer, DC.

This AUTHORIZATION is requested by Donna M. Archer, DC for its own use/disclosure of PHI.
(Minimum necessary standards apply.)

You have the right to refuse to sign this AUTHORIZATION.

If you refuse to sign this AUTHORIZATION,
Donna M. Archer, DC will not refuse to provide treatment.

You have the right to inspect or copy the PHI to be used / disclosed.
A COPY OF THE SIGNED AUTHORIZAITON WILL BE PROVIDED TO YOU

___________________________ ________________________________ _______________
PRINT NAME OF PATIENT SIGNATURE OF PATIENT OR GUARDIAN DATE

If you have a personal representative, please provide their name, signature and description of your representative's authority to act for you (the patient) below or on the back of this form.

Focus on wellness with chiropractic. . . . . .