AUTHORIZATION TO RELEASE INFORMATION AND ACKNOWLEDGEMENT OF PRIVACY PRACTICES

By signing below I authorize the release of any medical or other information necessary to diagnose or treat the above listed patient or to coordinate care with other healthcare providers who may be directly and indirectly involved in care. I also authorize the release of any medical or other information necessary to process insurance claims, obtain payment for health care bills from third-party payers, for coordinating care with other healthcare providers who may be directly and indirectly involved in care, and/or for conducting health care operations of Ruff Chiropractic, LLC such as quality assessment, accreditation or staff training. I also authorize Ruff Chiropractic, LLC to contact me by telephone, text, email, or mail. I authorize staff of Ruff Chiropractic, LLC to leave a message with information about my care or my appointments at the numbers I provide them.

I have been provided access to, have read, and agree to the Notice of Privacy Practices of Ruff Chiropractic, LLC. I understand that this notice is posted online at ruffchiropractic.com and that I can request a physical hard copy be given to me. I understand this Notice describes my rights and the duties of Ruff Chiropractic, LLC concerning my protected health information. I understand that Ruff Chiropractic, LLC may change the privacy practices that are described in the Privacy Notice, and I may obtain a revised Notice by reviewing it online at any time.

I authorize release of any medical or other information to the following family members or individuals:

_____ _____ _____ _____

Name of Individual & Relationship to Patient Name of Individual & Relationship to Patient

I authorize Ruff Chiropractic, LLC to contact me regarding protected health information via the following methods:

_____ _____ _____

Phone Text messaging Email

_____ _____ _____

Patient name (print) Patient/ Guardian signature Date