H2 Chiropractic Clinic
2001 Central Circle Suite 108
McKinney, Texas 75069
972-548-2225

CHIROPRACTIC AUTHORIZATION AND RELEASE FORM

NAME_____DATE_____

___I, understand my medical records are confidential and give Dr. Hardin and staff, permission to protect my confidentiality with what ever procedure they deem appropriate.
___I authorize release of any medical information necessary to process my claim.
___I, hereby give permission for my x-rays to be displayed in the clinic.
___I, hereby give permission for my name to be displayed on sign in and sign out sheets.
___I, hereby give permission for the doctor or staff to call me at home or work.
___I, hereby give permission for the clinic to use my name when speaking to me.
___I, hereby give permission for the doctor and staff to use the United States Postal Service or e-mail to contact me.
___I, hereby give doctor Hardin and staff permission to store my medical records in their current filing system.
___I, hereby give the staff permission to leave messages when trying to contact me.

SIGNATURE_____DATE_____

TERMINATION OF CARE WAIVER

I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my attending Doctor, whom has full and complete rights to terminate my case.

SIGNATURE_____DATE_____

CONSENT OF TREATMENT OF MINOR CHILD

I hereby authorize Dr. Sammy Hardin, or whomever he may designate as his assistants, to administer Chiropractic Care as he deems necessary to my _____. (Relationship)

NAME OF DEPENDENT_____

SIGNATURE OF GUARDIAN_____DATE_____

I have read and understand my rights as a patient.

_____
Patient Date

_____
Witness Date