DAVID M. ISRAEL, D.C.

IN PULSE CHIROPRACTIC, P.C.

1212 E. Baseline Rd. Suite 100
Tempe, AZ 85283
480 449-3300
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HEALTH CARE AUTHORIZATION FORM

Patient's Name _____

SS# _____ Date of Birth _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES IN PULSE CHIROPRACTIC TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI) IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

- ☐ I give permission to In Pulse Chiropractic, P.C. to use my address, phone number and clinical records to contact me regarding health related issues, treatment alternatives, practice promotions, and thank you cards.
- ☐ I give In Pulse Chiropractic, P.C. permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should it be necessary to speak with the doctor at any time in private, the doctor will provide a room for these conversations.
- ☐ I give In Pulse Chiropractic, P.C. permission to use and disclose my protected health information in accordance with my direct requests and in accordance with the directives listed above.

Your records must be maintained for 6 years after your last visit, per Federal and Arizona law. If you are a minor, the file is kept for 6 years after you reach age 18. Signing below gives us permission to shred your records 6 years after your last visit.

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 to taken action in reliance on your authorization.
You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of In Pulse Chiropractic.
The written notice must contain the following information:
Your name, social security number and date of birth; a clean statement of your intent to revoke this AUTHORIZATION; The date of your request; and your signature.
The revocation is not effective until it is received by the privacy officer.
This AUTHORIZATION is requested by In Pulse Chiropractic, P.C. 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, In Pulse Chiropractic will not refuse to provide treatment.
You have the right to inspect or copy the PHI to be used / disclosed.

INFORMED CONSENT TO CHIROPRACTIC CARE

I request and consent to the performance of chiropractic examination, adjustment, and other procedures, including modes of physiotherapy, on me (or the patient named below, for whom I am legally responsible). I understand that the results of treatment are not guaranteed. I understand and am informed that in the practice of chiropractic, as in the practices of medicine, there are some risks to treatment, and although rare, include but not limited to, fractures, disc injury, stroke, dislocations and strain. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. This consent form covers the entire course of treatment for my present condition and for any future condition for which I seek treatment.

- A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU UPON REQUEST

_____ _____
Print patient name Signature of Personal representative

_____ _____
Signature of patient Description of representative's authority to act for patient

_____
Date