Fort Wayne Chiropractic

Dr. Gregory J. Hough, D.C.

PERMISSION TO SHARE LIMITED HEALTH INFORMATION WITH FAMILY/FRIENDS

Patient Name (print): ________________________________ **Date Of Birth** ____________________

By signing this paper below, I give permission to the person(s) listed in the table below to receive limited information about my care. I understand my healthcare provider will use their professional judgment to ensure that information is shared with my family/friends in order to assist with my continuing care. Any information requested that does not pertain to assisting with my health care and any requests for copies of medical records will require a signed HIPPA compliant authorization. This permission will be considered ongoing until I state in writing otherwise.

ALL COLUMNS MUST BE FILLED OUT FOR EACH PERSON LISTED →

Date of permission	**Name** of individual & **Relationship** with patient (parents for minors and spouses must be added if they are to have any access)	**Specify Information Allowed** (i.e. may call about appointment, may check balance, full access, etc.)
		❒ Appointment information ❒ May check balances ❒ Full access ❒ Other ______________
		❒ Appointment information ❒ May check balances ❒ Full access ❒ Other ______________
		❒ Appointment information ❒ May check balances ❒ Full access ❒ Other ______________
		❒ Appointment information ❒ May check balances ❒ Full access ❒ Other ______________

DR. HOUGH/STAFF HAS MY PERMISSION TO: (Please check all that apply)

❒ Leave detailed message **at home** with my spouse

❒ Leave detailed message **at home** with: NAME: ______________________ Relationship: ____________________

❒ Leave detailed message on my **cell phone** Cell phone number: ______________________

❒ Leave detailed message on my **home answering machine** Home phone number: ______________________

❒ Leave detailed message on my **voicemail at work** Work phone number: ______________________

In order to obtain information by telephone, the party calling Fort Wayne Chiropractic must be able to share the patient's date of birth with the staff.

______________________________________ ____________________

Signature of patient or legal guardian Date