Seahurst Chiropractic & Wellness Center
(206) 242-8211

AUTHORIZATION TO RELEASE INFORMATION TO FAMILY MEMBERS

Many of our patients allow family members such as spouse, parents, and/or others to call and request information regarding account details, medical, and billing information. Under the requirements of HIPPA, we are not allowed to give this information to anyone without the patient's prior consent. If you wish to have your medical or billing information released to family members, you must sign this form. Signing this for will only give consent to release this information to the family members listed below.

You have the right to revoke this consent in writing.

I allow Seahurst Chiropractic & Wellness Center to release my medical and/or billing information to the following individual(s):

_____Relationship to patient_____

_____Relationship to patient_____

_____Relationship to patient_____

AUTHORIZATION TO LEAVE MESSAGES WITH HOUSEHOLD MEMBERS/ANSWERING MACHINE:

Sometimes it is necessary for our staff to leave messages for patients. The purpose of these messages are to remind patients of scheduled appointment times, discuss findings, or to speak with the patient regarding an issue or concern. The purpose of this consent is to leave messages with family members of your household or on your answering machine.

You have the right to revoke this consent in writing.

Patients name:_____

Patients signature:_____Date:_____