Crawford Chiropractic

King Chiropractic, PC
John D. Crawford, D.C.

Location Address:
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Mailing Address:
P.O. Box 2190
Ft. Oglethorpe, GA 30742

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PATIENT NAME:_____ DATE OF BIRTH:_____

Purpose of Consent: By signing this consent, you are consenting to the use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations by Dr. Crawford and his staff at Crawford Chiropractic (King Chiropractic, PC). You also give consent for any other medical records to be released to this office from any other facility upon request.

Notice of Privacy Policy: Our Notice of Privacy Policy provides a description of the uses and disclosures we make of your health information. You have the right to read this notice before you decide whether to sign this consent. You also have the right to obtain a copy of our Notice of Privacy Policy at any time.

Right to Revoke: You have the right to revoke this consent at any time by giving us a written notice of your revocation submitted to the Contact Person listed below. This revocation does not affect any action we took in reliance on this consent before we received your revocation and we may decline any further treatment if you revoke this consent.

Patient/Doctor Communication: By signing this consent, you give the right for Dr. Crawford and his staff at Crawford Chiropractic (King Chiropractic, PC) to contact you via text, email or phone call or mail regarding your treatment, account and other communication.

Signature: By signing below, I have had the full opportunity to read and consider the contents of this consent and Notice of Privacy Policy. I understand that I am giving my consent to Crawford Chiropractic's use and disclosure of my protected health information to carry out treatment, payment activities, patient/doctor communication and health care operations.

SIGNATURE: _____ Date:_____

If this consent is signed by a personal representative/guardian on behalf of the patient, complete the following:
Personal Representative's Name: _____
Relationship to Patient: _____

You may obtain a copy of our Notice of Privacy Practices Policy, including any revisions, and this consent at any time by contacting Brittney Jackson, RN – (706) 891-1011 – crawfordchiro97@gmail.com