KELLING CHIROPRACTIC HIPAA AUTHORIZATION

Please list the individuals that you allow Kelling Chiropractic to contact about your appointments, bills and/or treatment plan.

Name: _____

Relationship: _____

Phone Number: _____

Name: _____

Relationship: _____

Phone Number: _____

Name: _____

Relationship: _____

Phone Number: _____

By signing this form you are allowing Kelling Chiropractic to contact the individuals listed above about your medical information.

Printed Name: _____

Signature: _____

Date: _____