Alan R. Post, D.C., Inc.

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Consent for Use or Disclosure of Health Information

Patient Name: ______________________________ DOB: __________ Date: _________

This authorization will become part of your permanent record. It is your responsibility to inform us of and changes.

If I am referred to another physician, I give Dr. Post permission to send any information needed and in turn, I authorize them to send my reports or results to Dr. ________. This authorization also applies to any hospital or clinic.

Initials: _______________

If in my best medical interest it is necessary to fax my medical records to another physician, hospital, or clinic, I authorize this procedure.

Initials: _______________

I understand that I will be held responsible for payment of any services rendered in the best interest of my medical care that are not covered by my insurance carrier.

Initials: _______________

If my home is equipped with an answering machine or voice mail service and I cannot be reached personally, I authorize detailed messages regarding results, appointment notices, etc. be left on my answering machine or voice mail service.

Initials: _______________

I authorize detailed messages regarding results, appointment notices, etc. to be texted to my phone or e-mailed to me.

Initials:________________

I authorize Dr. Post to release any information required to process my claim(s). I hereby assign my insurance carrier benefits to be paid directly to the physician.

Initials: _______________

I authorize that all test results, appointments, and billing information can be released to my husband/wife or other. If other, please indicate the name(s) of person(s) below.

Other(s):____________________________ Relationship: _________________________

Signed: ____