

Inner Balance



*Chiropractic and Wellness Center
"Improving Health and Enriching Lives"*

**PATIENT AUTHORIZATION FOR CONTACT REGARDING
WELLNESS CARE, RELATED HEALTH SERVICES
AND/OR RELATED HEALTH PRODUCTS.**

Under federal law we are required to ask for your permission to leave a message regarding confirmation of your appointment times and meetings and relaying product information. The purpose of this use is to make a more pleasant, personable, efficient and productive Wellness Center as well as further enhancing your access to quality health care.

If you choose not to authorize this information use, your decision will have no adverse effect on your care from our office or on your relationship with our staff.

Your signature indicates your authorization of this activity.

_____ Please check here if there is an alternate number to be reached where you prefer we leave messages. Please enter the number here: (____) _____

NAME (PRINTED)

SIGNATURE

DATE

You may revoke this authorization at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change to be completed.

Rev. 8/07 W.A.V.E.