Terry Hamilton, D. C.
4519 N Garfield, Suite 1 Midland TX 79705 (432) 685-0777

Appointments and Cancellation/No Show Policy

You may cancel/reschedule your appointment any time before the close of the business day prior to the day of your appointment without a fee. Same day cancellations, unless filled from the waiting list, will be charged the No Show fee.

Appointments without adequate cancellation notice or missed appointments will be charged a fee of 40.00 for standard Chiropractic Care and 60.00 for Acupuncture. These fees are the sole responsibility of the patient and must be paid in full at your next scheduled appointment.

We understand that special unavoidable circumstances happen and you may need to cancel your scheduled appointment the same day. Fees in this instance may be waived but only with management approval.

Patients will be seen in the order of their scheduled appointment time. If you arrive earlier than 15 minutes before your appointment there may be a wait time. Late appointments may have to reschedule.

Please check your insurance benefits for chiropractic care prior to your appointment. All fees not covered by insurance will be due at the end of the scheduled visit.

Please sign that you have read and agree to this policy.

_____
Patient Name or Patient Representative (Please Print)

_____ _____
Signature of Patient or Patient Representative Date

Confidential Information

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Patient Information

First MI Last

DOB Gender ☐ Male ☐ Female What you prefer to be called

Address City State Zip

Home Phone Work Phone

Cell Phone ☐ TEXT appointment reminders (need phone carrier)

Email

Account Information (Person Ultimately Responsible for the Account)

Responsible Party DL#

Address City State Zip

Emergency Contact: Relationship Phone#

Insurance Information

Primary

Insurance Company ID Group#

Insured's Name Insured's DOB

Your Relationship to insured: Self Spouse Child Other

Secondary

Insurance Company ID Group#

Insured's Name Insured's DOB

Your Relationship to insured: Self Spouse Child Other

Cancellation and No Show Policy

We request a 24-hour notice for appointment cancellations and changes so that we have sufficient time to fill your appointment time. This makes it possible for us to get those in who need care.
Missed appointments and no shows are billed at the following rate.

Manipulation appointment is billed at $40
Acupuncture appointment is billed at $60

These charges are the responsibility of the patient and will not be billed to your insurance company.

Non-covered charges

Insurance will not be filed for acupuncture, vitamins, DRX or supplies. These are not covered and are the patients' responsibility.

I authorize release of any information necessary to process my insurance claim. I assign and request payment directly to Terry Hamilton, D. C. I fully understand I am solely responsible for any balance not paid by my insurance company. Including charges that my insurance may deem unnecessary or not within reasonable and customary limits.

Signature of Patient or Guardian: Date

Confidential Information Terry Hamilton, DC
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Pain History

Describe your pain and symptoms:

_____

_____

Are you interested in more information about Acupuncture? _____

When did your pain first begin? (date): _____

Under what circumstances did the pain begin:

☐ Accident at work ☐ At work, but not an accident ☐ Accident at home ☐ Auto accident ☐ Following surgery
☐ Following an illness ☐ Pain just began ☐ Other reason: _____

Briefly describe the circumstance you checked:

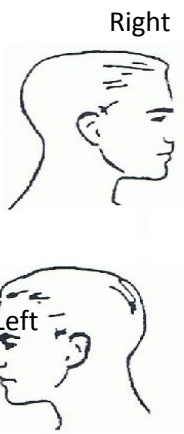
_____

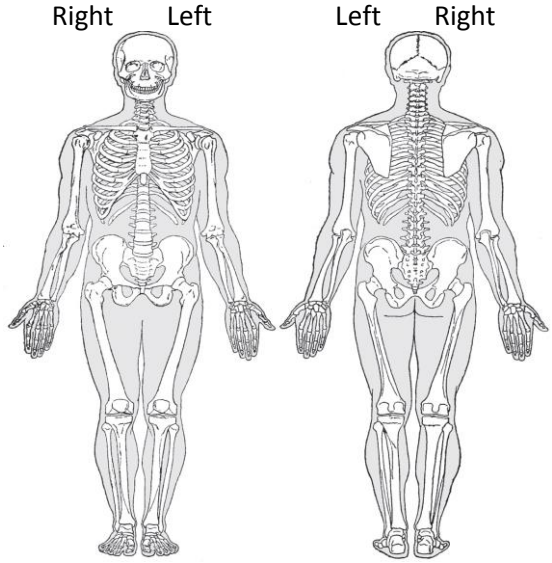
Location of Pain

Using the symbols listed below, mark on the drawings the areas where you feel pain. If you feel more than one sensation in the same area, mark over that area with additional symbols that apply. Show all affected areas.

Symbols (mark on drawing)

----------	Numbnes
0000	Pins and needles
xxxxx	Burning
//////	Stabbing
+++++	Aching
ssssss	Soreness
E	External (on or outside the body)
I	Internal (inside the body)





Quality of Pain

Please describe your pain. Mark ☒ all that apply:

☐ Aching	☐ Sharp pain	☐ Tender
☐ Burning	☐ Shooting	☐ Throbbing
☐ Cramping	☐ Soreness	☐ Tingling
☐ Dull	☐ Spasm	☐ Other _____
☐ Numbness	☐ Stiffness	

Pain Intensity

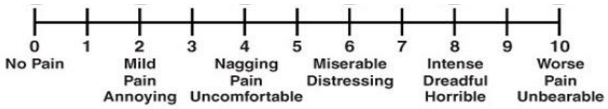
Which word (or words) best describe the patterns of your pain: ☐ Always present ☐ Comes and goes

Is your pain usually WORSE during a certain time of day? If yes, when: ☐ Morning ☐ Midday ☐ Evening ☐ Night

Is your pain usually BETTER during a certain time of day? If yes, when: ☐ Morning ☐ Midday ☐ Evening ☐ Night

Indicate your pain level at the PRESENT TIME

Indicate your pain level at its WORST



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Increases/Decreases Pain

Please mark ☒ how your pain reacts to the following:

	Better	Worse	No Change
Activity or movement			
Applying cold			
Applying heat			
Bending			
Cough or sneezing			
Driving			
Exercise			
Lifting			
Local pressure			
Lying down			

	Better	Worse	No Change
Massage			
Medications			
Pulling / Pushing			
Rest			
Sitting			
Standing			
Straining			
Stress or worry			
Walking			
Other			

Lifestyle Changes

During the past month, how much did pain interfere with the following activities?

	A Little Bit	Moderately	Quite a Bit
Work			
Mood			
Family function			
Sleep			
Concentration			
Recreation			

Prior Treatments for this pain

	Helpful	Not Helpful	
☐ Acupuncture.	☐	☐	_____
☐ Chiropractor.	☐	☐	_____
☐ Massage Therapy.	☐	☐	_____
☐ Medical Doctor	☐	☐	_____
☐ Nerve Block	☐	☐	_____
☐ Physical Therapy	☐	☐	_____
☐ Surgery.	☐	☐	_____
☐ Other	☐	☐	_____

Diagnositc Tests

	DATE	Facility
☐ CAT SCAN	_____	
☐ EMG	_____	
☐ MRI.	_____	
☐ Nerve Conduction Study	_____	
☐ XRAY	_____	

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Review of Systems

Please mark ☒ the following symptoms that you **currently suffer from**. NOTE: Diagnosed conditions/diseases should be noted under Past Medical History.

CONSTITUTIONAL

- ☐ Chills
- ☐ Easy Bruising
- ☐ Excessive Sweating
- ☐ Excessive Thirst
- ☐ Fatigue
- ☐ Fevers
- ☐ Insomnia
- ☐ Low Sex Drive
- ☐ Night Sweats
- ☐ Tremors
- ☐ Unexplained Weight Gain/Loss
- ☐ Weakness

EYES EARS NOSE THROAT

- ☐ Change in Vision-☐Reading ☐Driving
- ☐ Pain in Eye(s)
- ☐ Deafness/Difficulty Hearing
- ☐ Ringing in the Ears
- ☐ Earaches
- ☐ Nosebleeds
- ☐ Sinus Trouble
- ☐ Dental Problems
- ☐ Hoarseness
- ☐ Recurrent Sore Throats

GASTROINTESTINAL

- ☐ Acid Reflux
- ☐ Belching/Gas
- ☐ Black or Bloody Stools
- ☐ Change of Appetite
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty Swallowing
- ☐ Nausea
- ☐ Pain over Abdomen
- ☐ Poor Digestion
- ☐ Ulcer
- ☐ Vomiting

SKIN

- ☐ Acne
- ☐ Changes in Hair or Nails
- ☐ Changes in Mole(s)
- ☐ Dry skin
- ☐ Warts

RESPIRATORY

- ☐ Asthma
- ☐ Chronic Cough
- ☐ Shortness of Breath
- ☐ Snoring
- ☐ Tuberculosis
- ☐ Wheezing

CARDIOVASCULAR

- ☐ Chest Pain
- ☐ Fainting / Lightheadedness
- ☐ High Blood Pressure
- ☐ Irregular Heartbeat
- ☐ Previous Heart Trouble
- ☐ Shortness of Breath during sleep
- ☐ Swelling in the feet

GENITOURINARY

- ☐ Blood in Urine
- ☐ Difficulty Start Urine Flow
- ☐ Frequent Urination
- ☐ Inability Control Urination
- ☐ Kidney Stones
- ☐ Painful Urination
- ☐ Unusual urine color
- ☐ Urinary Infection
- ☐ Waking in the night to urinate

WOMEN ONLY

- ☐ Breast pain
- ☐ Decreased libido
- ☐ Hot Flashes
- ☐ Irregular Cycles
- ☐ Painful Periods
- ☐ Vaginal Burning/Itching/Sores

MEN ONLY

- ☐ Breast pain
- ☐ Decreased libido
- ☐ Itchiness
- ☐ Penile sores
- ☐ Testicular Swelling/Pain

NEUROLOGIC

- ☐ Abnormal gait/walking
- ☐ Carpal Tunnel Syndrome
- ☐ Dizziness/Blackouts
- ☐ Headaches
- ☐ Memory loss
- ☐ Numbness/Tingling
- ☐ Seizures
- ☐ Tremors
- ☐ Weakness

MUSCULOSKELETAL

- ☐ Arthritis
- ☐ Back Pain
- ☐ Bone Pain
- ☐ Joint Pain
- ☐ Muscle Spasms/Pain
- ☐ Neck Stiffness/Pain
- ☐ Stiffness

Psychiatric

- ☐ Anxious
- ☐ Depressed Mood
- ☐ Memory change
- ☐ Stress Problems
- ☐ Suicidal Thoughts

Physician only ☐All others negative

Past Surgical History

Abdominal Surgery

- Gallbladder removal
- Appendectomy
- Bypass surgery
- Other

Female Surgeries

- Caesarean section
- Hysterectomy
- Laparoscopy
- Other

Heart Surgery

- Valve replacement
- Aneurysm repair
- Stent placement
- Other

Joint Surgery

- Shoulder
- Hip
- Knee
- Other

Spine/ Back Surgery

- Discectomy (levels)
- Laminectomy
- Spinal fusion (levels)
- Other

Other Common Surgeries

- Hemorrhoid surgery
- Hernia repair
- Thyroidectomy
- Tonsillectomy
- Vascular surgery
- Cancer
- Cosmetic surgery
- Elective surgery
- Eye surgery

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Do you have any medical devices implanted in your body? ☐ Yes ☐ No
(i.e., pacemaker, portacath, pump, rods, prosthesis, stimulator etc.)

Previously Diagnosed Medical History

GENERAL

☐ Have hypermobile joints
☐ Had a spine or nerve disorder
☐ Been knocked unconscious
☐ Been injured in an accident
☐ HIV / AIDS
☐ Diabetes Type _____
☐ I am currently taking insulin
☐ Cancer
☐ Type _____

Medications taking for these conditions:

EYES EARS NOSE THROAT

☐ Headaches
☐ Migraines
☐ Head Injury
☐ Sinus Trouble
☐ Hyperthyroidism
☐ Hypothyroidism
Medications taking for these conditions:

GASTROINTESTINAL

☐ Bowel Incontinence
☐ GERD (Acid Reflux)
☐ Gastrointestinal Bleeding
☐ Constipation
☐ Hemorrhoids
Medications taking for these conditions:

RESPIRATORY

☐ Bronchitis
☐ Emphysema / COPD
☐ Asthma
☐ Sleep Apnea
☐ Tuberculosis
☐ Pneumonia
Medications taking for these conditions:

CARDIOVASCULAR / HEMATOLOGIC

☐ Anemia
☐ Bleeding Disorders
☐ Heart Attack
☐ High Blood Pressure
☐ High Cholesterol
☐ Mitral Valve Prolapse
☐ Murmur
☐ Stroke
☐ Poor Circulation
☐ Coronary Artery Disease
☐ Pacemaker / Defibrillator
Medications taking for these conditions:

GENITOURINARY / NEPHROLOGY

☐ Bladder Infection
☐ Dialysis
☐ Kidney Infection
☐ Kidney Stones
☐ Urinary Incontinence
Medications taking for these conditions:

NEUROPSYCHOLOGICAL

☐ Alcohol Abuse
☐ Alzheimer Disease
☐ Bipolar Disorder
☐ Depression
☐ Epilepsy
☐ Prescription Drug Abuse
☐ Multiple Sclerosis
☐ Paralysis
☐ Peripheral Neuropathy
☐ Seizures
☐ Reflex Sympathetic Dystrophy / CRPS
☐ Other Diagnosed Conditions
Medications taking for these conditions:

SKIN

☐ Acne
☐ Psoriasis
☐ Cancer
Medications taking for these conditions:

MUSCULOSKELETAL

☐ Amputation
☐ Bursitis
☐ Carpal Tunnel Syndrome
☐ Chronic Neck Pain
☐ Chronic Joint Pain
☐ Fibromyalgia
☐ Hyper flexible
☐ Joint Injury
☐ Loose Joints
☐ Rheumatoid Arthritis
☐ Osteoarthritis
☐ Osteoporosis
☐ TMJ issues
☐ Osteoporosis
☐ Tennis Elbow
☐ Vertebral Compression Fracture
Medications taking for these conditions:

Hepatic

☐ Hepatitis A (active / inactive / unsure)
☐ Hepatitis B (active / inactive / unsure)
☐ Hepatitis C (active / inactive / unsure)
Medications taking for these conditions:

WOMEN ONLY

☐ Painful Periods
☐ Sexually transmitted disease
☐ Vaginal Burning/Itching
☐ Hot Flashes
☐ ***Pregnant Due date*** ___/____/____
Date Last Period Began ___/____/____
Date of Last PAP Test ___/____/____
Medications taking for these conditions:

MEN ONLY

☐ Sexually transmitted disease
☐ Prostate Issues
Medications taking for these conditions:

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Other Current Medications

Date Started	*Medication*	*Dose/ How often*	*Benefit*

Allergies

Do you have any known drug allergies? ☐ YES ☐ NO
If so, please list all medications you are allergic to.

Medication Name **Allergic Reaction Type**

Topical Allergies ☐ **Iodine** ☐ **Latex** ☐ **Tape** **Are you allergic to shellfish?** ☐ **YES** ☐ **NO**

Family History

Has anyone in your family ever had any of the following conditions? Please mark all that apply.
☐ I AM ADOPTED (no medical history available)

	Father	Mother	Brother	Sister	Maternal / Paternal M or P Grandparent
Cancer					
Chronic pain					
Depression/Mental Illness					
Diabetes					
Drug Addition/Drug Abuse					
Heart disease					
High blood pressure					
Stroke					
Suicide					
Thyroid disease					
Cause of Death and age					

Social History

HABITS	WORK ACTIVITY	EXERCISE
☐ **Smoking ____Packs/Day ___Years** ☐ **Never smoked** ☐ **EX-smoker** ☐ Alcohol ☐ Caffeine Coffee Soda Tea	☐ Sitting ☐ Light labor ☐ Heavy labor ☐ Standing ☐ Computer work Do you like your job? ☐ Yes ☐ No Is it stressful? ☐ Yes ☐ No *Type of employment:*	☐ None ☐ 3-5 x Weekly ☐ 1-2 x Weekly ☐ 6-7 x Weekly ***Type of EXERCISE:*** COMMON SLEEPING POSTION ☐ Back ☐ Side ☐ Stomach

I certify that the above information is accurate, complete and true.

Patient Signature:

Terry Hamilton, DC
4519 N Garfield, Suite 1 Midland TX 79705 (432) 685-0777

NOTICE OF INFORMED CONSENT FOR TREATMENT

Every type of health care is associated with some risk of a potential problem. This includes chiropractic care. We want you to be informed about the potential problems associated with chiropractic care before consenting to treatment. This is called an informed consent.

A subluxation is a medical term that describes what occurs when one or more of the spinal (vertebral) joints have moved of its normal alignment. This can occur through recent or remote trauma as well as unusual positions in which we find ourselves throughout the day or night. A subluxation has also been described as an incomplete dislocation of a joint and with spinal manipulation (adjustments performed by hand or with the use of a specific tool) in order to gently reposition the misaligned segments. Frequently, adjustments create a popping sound or clicking sensation in the area being treated.

Stroke: Stroke is the most serious problem associated with spinal adjustment, regardless of whether the provider is a Chiropractor or Medical Physician, a stroke occurs when a portion of the brain does not receive enough oxygen from the blood stream. The result can be temporary or permanent dysfunction of the brain, with a rarer complication of death. Spinal adjustments have only been associated with strokes that arise from the vertebral artery. The specific neck adjustment that is related to this complication is never performed in this office. The most recent studies (Journal of the California Chiropractic Association Vol. 37, No. 26-93) estimates that the incidence of this type of complication occurs in 1 (one) in every 3,000,000 (three million) adjustments to the neck. This means that the average chiropractor would have to practice over 100 years before they would be statistically associated with a single patient stroke.

The most effective method of lessening the odds that a patient is prone to a stroke is through careful screening of risk factors in the history, including medications taken as well as a family history of high blood pressure and specific exam procedures to assess blood flow to the brain.

Disc Herniation: Disc herniations that create pressure on nerves or the spinal cord are frequently treated successfully by Chiropractors using adjustments, distraction, and other therapies. This includes both in the neck and the low back. Yet, occasionally Chiropractic treatment will aggravate this problem. To help prevent this, patients are put through specific range of motion tests and procedures during the examination to see if any of these positions might aggravate disc symptoms. Because of that there are no available statistics to qualify their probability.

Soft Tissue Injury: Soft tissue refers primarily to the muscles, tendons, and ligaments. Muscles move bones and ligaments limit joint movement rarely a Chiropractic adjustment, traction, massage, etc. may strain some muscle or ligament fibers. The result is a temporary increase in pain requiring specific treatment for resolution, with no long term affects to the patient. These problems occur so rarely that there are no available statistics to qualify their probability.

Rib Fractures: The ribs are found attached to the thoracic spine in the middle back. They extend from your back to the front of the chest. Rarely a Chiropractic adjustment may break a rib. This is referred to as a fracture. This occurs only to those patients who have weakened bones from such things as osteoporosis, prolonged steroid use, or other bone weakening diseases. This can be ruled out in the history or x-rays. We adjust all patients carefully and especially those with bone weakened conditions. This problem occurs so rarely that there are no statistics available to qualify their probability.

Physical Therapy Irritations: Some therapeutic machines and analgesic balms generate heat. We use different forms of heat and ice in the office and occasionally recommend them for use at home. Everyone's skin has a different sensitivity to these modalities, and rarely heat or ice can irritate the skin. The result is temporary increase of skin pain and possibly their probability.

Soreness: It is not uncommon for spinal adjustments, distraction, massage, exercise, etc. to result in a temporary increase in soreness in the area being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please DO TELL the doctor or a staff member about it.

Other Problems: There may be other problems or complications that may arise from Chiropractic treatment other than those mentioned above. These other complications occur so rarely that it is impossible to anticipate or explain them all in advance of treatment.

Chiropractic is a system of health care delivery, and therefore, as with any health care delivery system, we cannot promise a cure for all symptoms, diseases, or conditions as a result of treatment at this facility. We will always give you the best care that we can deliver and if the results are not acceptable, we will gladly discuss other types of treatment options or refer you to another health care provider for alternative types of treatment.

If you have any questions on the above information, please ask Dr. Hamilton to explain them more fully. When you have a full understanding of this material please sign and date this document below.

Patients Signature Parent/Guardians Signature Date

Notice of Privacy Practices.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and disclosures of health information - We seek your consent to use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. You can revoke your consent.

We may use or disclose identifiable health information about you without your authorization for several reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area and in each examination room. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

Individual rights - In most cases, you have the right to look at or get a copy of health information about you that we use to make decisions about you. If you request copies, we may charge you for this service. You also have the right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment or related administrative purposes. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

Complaints - If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

Our legal duty - We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

If you have any questions or complaints, please contact:

Terry Hamilton, D.C.
4519 N Garfield Suite 1
Midland TX 79705
432-685-0777

PLEASE KEEP THIS PAGE FOR YOUR RECORDS

Terry Hamilton, DC
4519 N Garfield, Suite 1 Midland TX 79705 (432) 685-0777

HIPPA Consent Form

The Health Insurance Portability and Accountability Act of 1996 (HIPPA), established a privacy rule to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate of necessary, we provide the minimum necessary information only to those we feel are in need of your health care information regarding treatment, payment or health care operations, in order to provide health care that is in your best interest.

We fully support your access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with the physician and not patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations, These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be done in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information. If you choose to give consent in this document, at some future time you may request to refuse all or part of your Personal Health Information. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer (Dr. Hamilton). You have the right to review our Privacy Notice (Compliance Assurance Notification to Our Patients), to request restrictions and revoke consent in writing.

I have been given the opportunity to and understand that I have a right to review the Practice's Notice of Privacy Practices prior to signing this document, which explains in further details how my medical information will be used and disclosed.

Patient or Guardian Signature Date

Witness Signature Date

Terry Hamilton, DC
4519 N Garfield, Suite 1 Midland TX 79705 (432) 685-0777

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I, _____ authorize _____ to release my Protected Health Information, as described below, to:

TERRY HAMILTON DC
4519 N Garfield Suite 1 Midland TX 79705
432-685-0777 fax 432-685-0778

I request that the information to be released consist of the following (CHECK ALL THAT APPLY):

___ Complete Medical Record ___ Medical History, Evaluation Records ___ Immunizations

___ Treatment or Tests ___ Hospital Records Including Reports ___ X-ray Reports

___ Allergy Records ___ Laboratory Reports ___ Prescription Data

___ Consultation Documentation ___ Surgical Reports

___ Other (Specify):_____

I also specifically authorize that any sensitive information regarding (CHECK ALL THAT APPLY):
___ HIV/AIDS,
___Substance Abuse (alcoholism or drug abuse), or
___Mental Health be released to the above referenced recipients.

It is my understanding that the information to be released will be used for the following purposes. (CHECK ALL THAT APPLY):

___ At the request of the individual (no purpose need be specified) ___ Additional Medical Care

___ Insurance Eligibility/Benefits ___ Change of Provider ___ Legal Investigation or Action

___ Other (Specify): _____

I understand that if the authorized recipient is not a provider, health plan, or clearinghouse required to comply with federal privacy standards, the information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards and my health information may then be disclosed by the recipient without obtaining any further authorization.

INDIVIDUAL'S RIGHTS RELATING TO THIS AUTHORIZATON:

I understand that I may be provided with a copy of this form if I choose to sign it. I understand that I am under no obligation to sign this form and that the practice may not condition my treatment, payment, or enrollment/eligibility for benefits on my decision to sign this form. I understand that I may revoke this Authorization by notifying the practice in writing of my revocation. To obtain information on how to revoke my Authorization or to receive a copy of my revocation, I am to contact: Dr. Terry Hamilton at 432-685-0777 . I am aware that my revocation will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reliance on this Authorization.

EXPIRATION DATE: This Authorization is valid until _____.

I have had an opportunity to review and understand the content of this Authorization form. By signing this Authorization, I am confirming that it accurately reflects my wishes.

_____ _____

Name of Patient or Legal Representative (Printed) **Signature of Patient** or Legal Representative

Description of Legal Representative's Relationship _____

Witness_____ Date _____

(This authorization is valid as of the date signed above)