Patient Authorization regarding chiropractic care being provided in an open environment…

It is the practice of this office to provide health care in an "open" environment. "Open" environment care involves several patients being in the same room at once. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for consultation, history taking, performing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting.

We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as an "incidental disclosure" of health information. It is our view that the kinds of matters related in an "open" environment are incidental matters, in the event your or someone else would not agree with us we are providing disclosure.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an "open" environment, other arrangements will be made for you. Your decision will have no adverse effect on your care from Dr. Tobin or on your relationship with our staff.

Your signature indicates your authorization of this activity.

_____	_____	_____
Name (printed)	Signature	Date

This authorization may be revoked by you 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 in your procedures to be completed.

Patient Authorization for contact regarding chiropractic care, related health services and/or related health products…

It is our desire for our staff to use your name, address and/or telephone number for the purpose of contacting you to advise you about health related appointments, meetings, workshops and products.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information.

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

Your signature indicates your authorization of this activity.

_____	_____	_____
Name (printed)	Signature	Date

This authorization may be revoked by you 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 in your procedures to be completed.