PETESON CLINIC

Kristopher B. Peterson,DC, DABCI, BCN, FICT
Chiropractic Internest

Trent J. Teegarden, DC, *Chiropractic Physician*
Anton L. Alder, ND, *Naturopathic Physician*

PERMISSION TO SHARE PATIENT HEALTH INFORMATION

_______________ / I, ________________________________ / ______________________

Todays Date: (Patients Name-PLEASE PRINT) (Date of Birth)

Authorize those named below to:

1- Name: ____

	Discuss any or all medical or financial information regarding my care
	Request or receive any or all medical or financial information regarding my care
	Receive information regarding HIV, STD, or other sexually related information
	Bring the above named patient to his/her provider appointments
	Other- please specify:

2- Name: ____

	Discuss any or all medical or financial information regarding my care
	Request or receive any or all medical or financial information regarding my care
	Receive information regarding HIV, STD, or other sexually related information
	Bring the above named patient to his/her provider appointments
	Other- please specify:

3- Name: ____

	Request or receive any or all medical or financial information regarding my care
	Receive information regarding HIV, STD, or other sexually related information
	Bring the above named patient to his/her provider appointments
	Other- please specify:

DECLINE: ________Please do not communicate any information about my care at Peterson Clinic with my famiy members or friends.

This information is updated **ANNUALLY**, in order to protect your privacy; **it is your responsibility to inform our office of any changes that occur throughout the year.**

SIGNATURE: ______________________________________ DATE: ________________________

(Patient or Parent/Guardian

- -

PC OFFICE USE ONLY

WITNESSED: ______________________________________ DATE: ________________________