

**Back To Health Chiropractic**  
**120 Tompkins St**  
**Cortland, NY 13045**

**Patient Privacy Form**

Name \_\_\_\_\_

Your Emergency Contact is \_\_\_\_\_ Phone# \_\_\_\_\_

Their relationship to you \_\_\_\_\_ Cell# \_\_\_\_\_

\*Is this the person authorized to take messages regarding appointments and or other information, this includes Medical Record Information? YES/NO

HIPPA (PRIVACY) DOCUMENTATION:

1. I acknowledge, I have been given a copy of the Back To Health Chiropractics Privacy Notice:  
Initials \_\_\_\_\_
2. I give my permission to leave messages from this office in regards to:

OFFICE APPOINTMENTS, MEDICAL, & BILLING INFORMATION

Home Answering Machine:	Yes/No
Office Voice Mail:	Yes/No
Cell Phone Voice Mail:	Yes/No
E-mail	Yes/No

I authorize the Emergency Contact (above) and the following person (s) to take messages or discuss the above information if I am not available

Name: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone# \_\_\_\_\_

Name: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone# \_\_\_\_\_

\*\*\*\* I have completed all the information to the best of my ability  
\*\*\*\* I consent to have the practice use and disclose my protected health information for payment, treatment, and health care operation purposes an for other such purposes that are permitted under the HIPPA or other federal or state laws without written permission.

Patient Signature \_\_\_\_\_ DATE \_\_\_\_\_