# ACTIVE SPINE & SPORTS CARE

CHIROPRACTIC · WELLNESS

**Patient Name:** _____ **DOB:** _____

The state of California mandates that medical information may be shared only with the patient, or the patient's legal representative. In accordance with this law, every employee of Active Spine & Sports Care is required to sign a Confidentiality Statement on an annual basis, indicating that they will keep the medical information of every patient in the strictest of confidence.

The Staff and /or Chiropractor cannot release medical information to family members of patients without permission from the patient or the patient's legal representative.

If you wish to give permission for the staff and/or chiropractor to verbally release general medical information to family members list the name(s) and relationships of those individuals in the space provided below. General medical information excludes the discussion of psychiatric services, drug and alcohol counseling, sexually transmitted disease, HIV testing and pregnancy or termination of pregnancy.

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

***I authorize that the above individual(s) may have access to information regarding my general medical condition. I will notify Active Spine & Sports Care in writing if I wish to add or delete individuals who may have access to my medical information.***

**Signature of Patient**: _____ Date: _____

---

In the event we need to contact you regarding lab/ test results or other sensitive information, may we leave a detailed message on your voicemail?

☐ **YES**
Phone Number(s) Cell: _____ Home: _____
☐ **NO**

**Signature of Patient**:_____ Date: _____