HIPAA HAPPENINGS

The Chiropractic Office of John G. Murray Jr. D.C.

Patient Authorization regarding chiropractic care being provided in an "open-door" adjusting environment.

It is the desire of this office to provide chiropractic care in an "open-door" adjusting environment. An "open-door" approach involves the doctor moving from patient care area to patient care area and leaving the door between patient care areas open. As a result patients are occasionally 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 taking patient histories, 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 disclosures" of health information. It is our view that the kinds of matters related in an "open-door" environment are incidental matters, in the event you or someone else would not agree with us we are providing this disclosure and requesting your authorization.

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. If you choose not to be adjusted in an open-door adjusting environment other arrangements will be made for you. Your decisions will have no adverse effect on your care from Dr. Murray or 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 reasonable processing time for the changes in our procedures to be completed.

HIPAA HAPPENINGS

The Chiropractic Office of John G. Murray Jr. D.C.

Patient Authorization for appointment reminders and scheduling related matters.

It is our desire to for our staff to use your name, address, and/or telephone number for the purpose of contacting you to remind you about scheduled appointments, re-evaluations or other appointment related issues.

The use of this information is intended to make your experience with our office more efficient and productive. If you choose not to authorize this information use your decision will have no adverse effect on your care from Dr. Murray or 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 reasonable processing time for the changes in our procedures to be completed.