Rise Chiropractic and Wellness

Coordination of Care, Communication & Disclosure Authorization

This document authorizes Rise Chiropractic and Wellness to communicate, disclose information, and coordinate care as outlined below. Please read carefully and indicate your permissions.

Patient Information

Patient Name: _____ DOB: _____ Date: _____

Authorized Individuals

Name	Relationship	Information Authorized	Duration

Types of Information That May Be Shared

• Appointment scheduling, confirmations, cancellations, and rescheduling
• Medical records including diagnoses, treatment plans, and progress notes
• Billing and payment information, balances, receipts, and account status
• Authorization for designated individuals to schedule or cancel appointments and to pick up or purchase supplements or products on the patient's behalf

Communication Consent

I authorize Rise Chiropractic and Wellness to contact me via phone call, text message, and/or email for appointment reminders, scheduling changes, billing notifications, care-related communication, educational updates, wellness resources, and practice-related announcements. I understand that message frequency may vary and that standard message and data rates may apply.

__◉__ I consent to care-related communications
__○__ I do not consent to care-related communications (except where required for care delivery)

Marketing & Educational Communications

I understand that Rise Chiropractic and Wellness may also send optional marketing, promotional, or educational communications including newsletters, wellness content, event invitations, service updates, or special offers. Consent to receive these communications is voluntary and not required to receive care.

__◉__ I consent to receive marketing and educational communications
__○__ I do not consent to receive marketing or educational communications

Revocation & Duration

This authorization remains in effect unless and until it is revoked, modified, or replaced by the patient in writing, or superseded by a future attestation, addendum, or updated authorization completed by the patient. The patient understands that they may update or revoke this authorization at any time by submitting a written request, and that routine annual reviews or attestations may be used to confirm or update these permissions.

Acknowledgment

By signing below, I acknowledge that I have read and understand this authorization and consent to the disclosures and communications described above.

Printed Name: _____

Signature: _____ Date: _____