503 E CLAIREMONT AVENUE * EAU CLAIRE, WI 54701 * PHONE: 715-832-2223 * FAX: 715-832-7416

Patient name: _____ DOB: _____

AUTHORIZATION FOR VERBAL COMMUNICATION

👉**Whom may we speak to on your behalf about scheduling and/or billing**

(List First and Last Names of Person(s) To Whom Your Information May Be Disclosed, Such as Parents, Spouse, Etc).

I authorize communication between :_____

_____

And the doctor(s)/staff of:

O MJ Gonstead LLC
O Arkowski Chiropractic LLC
O Stangl Chiropractic & Massage Therapy LLC
O Jennifer Gonstead Chiropractic LLC

AUTHORIZATION TO LEAVE VOICEMAIL/TEXT MESSAGES

👉**May we leave a voicemail or text about scheduling and/or billing**

O Leave Voicemail/Text at the Following Number(s)_____

Cell Phone provider: O Verizon O T-Mobile O AT&T O _____ (Other)

I authorize to leave messages with:

O Anyone O Names of authorized individuals listed above

👉This authorization will expire **one year** from date signed, unless otherwise indicated:

O Indefinite O Other end date: _____ (MM/DD/YYYY)

In accordance with the conditions listed above, I authorize the use and/or disclosure of my medical information pertaining to appointments and billing at this office. This does not authorize the release of copies of medical records.

Signature of Patient/Representative: _____

Date: _____

If signed by persons other than the patient, please print name and state relationship to patient.

Print Name: _____*Relationship:* _____