

# HIPAA AUTHORIZATION

The Chiropractic Office of Dr. M.K. McKinnon

## Patient Authorization for appointment reminders and various mail communications

It is my desire for our staff to use your name, address, email address, and/or telephone number for the purpose of contacting you to remind you about scheduled appointments, reevaluations or other appointment related issues. We also send thank you notes, welcome letters, birthday cards and emails and occasional special promotions.

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 use of information, your decision will have no adverse effect on your care from Dr. McKinnon or on 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 you desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.

**McKinnon Chiropractic, Melanie McKinnon, DC, DACNB**

Diplomate of the American Chiropractic Neurology Board

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