MAGNOLIA NATURAL HEALTH

www.magnolianaturalhealth.com

Health Care Authorization Form

Patient's Name: _____

Patient's SS#_____ Date of Birth: _____

The patient identified above authorizes Magnolia Natural Health (MNH) to disclose protected health information in accordance with the following:

Specific Authorizations

I give permission to MNH to use my address and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, information about treatment alternatives, or other health related information.

I give MNH permission to contact me by phone or email, to leave a messages or information on my answering machine or voice mail.

You may also contact me by email.

Other: Video and written testimonials, office referral boards, newsletters

By signing this form you are giving MNH permission to use and disclose your protected health information in accordance with the directives listed above.

Patient Signature: _____ Date: _____

Expiration

The authorization will expire 7 years from the date signed above.