RODNICK CHIROPRACTIC LIFE CENTER

4604 North Saginaw Road
SUITE A
MIDLAND, MI 48640

11245 N. Mission Rd
Clare, MI 48617

6165 Bay Rd
Saginaw, MI 48604

MARKETING AUTHORIZATION

From time to time our practice would like to make you aware of products or services that you may have an interest in purchasing. This marketing could be done by our internal staff or by an outside marketing organization. Your chiropractor and members of the practice staff may need to use your health information including your name, address, phone number, and your clinical records for the purpose of marketing products and services from _____to you. We are specifically requesting authorization to market the following products and/or services to you: NEWSLETTERS

You may restrict the individuals or organizations to which your health care information is released or revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by the organization/s listed above and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us permission, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you for marketing purposes at any time. Our practice and staff will receive direct or indirect remuneration from our marketing activities.

This notice is effective as of March 1, 2003. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

_____ _____
Patient Name Printed Date

_____ _____
Patient Signature Authorized Provider Representative

_____ _____
Personal Representative Printed Personal Representative Signature

_____
Description of personal representative's authority to act for the patient.