Ray-Pec Lab Requisition

Date ____/_____/____ Office Case # _________

Name ____ Contact phone number __________________________

Address _______________________________________ City ____

State _________________ Zip __________________ Birth Date _____________ Age ___ Gender M F

___ Single ___ Married ___ Widowed ___ Divorced Height _____ft. In. _____ Weight ___

Contact e-mail address ____

By documenting your email address on this page, you are agreeing that health information for yourself can be freely shared via email between yourself and Eckert Chiropractic Center, PC. While usually considered safe, email is not the most secure method of sharing personal information.

Parent or Legal Guardian Signature ____ Date _____________________

NUTRITIONAL INFORMED CONSENT

According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG" is defined to mean: "Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease." A vitamin is not a drug, NEITHER is a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy. Although a Vitamin, a Mineral, Trace Element, Amino Acid, Herb or Homeopathic Remedy may have an effect on any disease process or symptom, this does not mean that it can be misrepresented or be classified as a drug by any one.

Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as a primary treatment and/or therapy for any disease or particular bodily symptom.

Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and biomechanical Processes of the human body. Nutritional advice and nutritional intake may also enhance the stabilization of chiropractic adjustments and treatment.

I have read and understand the above.

Parent or Legal Guardian Signature ____ Date _____________________

(Cash or Check Only)

HIPAA Privacy Authorization Form

**Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

Authorization

I authorize Dr. Charles Eckert to use and disclose the protected health information of the student described below to the Track team coaching staff at Ray Peck High School.

____

(Printed name of the student)

Effective Period

This authorization for release of information covers the blood lab results only for a period of 30 days after the results are obtained by Dr. Eckert at Eckert Chiropractic Center, PC.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.

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(Signature of Parent or Legal Guardian)

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(Printed name of Parent or Legal Guardian)

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(Date)