

Acknowledgement and Agreement:
Patient's Protocol for Records Preservation

I, _____, patient of Dr. Carrion, do hereby acknowledge I have read and understood the doctor's protocol for the preservation of patient records. I agree to inform Dr. Carrion's office of any address changes and acknowledge that all requests for records, either by me or my representatives, must be in writing. I agree that the doctor's office may comply with all statutory notification requirements to me by regular mail to my indicated address, which is on file at this office.

Patient Signature: _____

Patient Messaging Consent

By supplying my mobile phone number, email address, and any other personal contact information, I authorize Carrion Chiropractic Clinic to use my personal information, for the purpose of notifying me of a pending appointment, a missed appointment, or other communications via an automated outreach and messaging system. I consent to receiving appointment reminder texts on scheduled appointment days, or general office update messages from the automated outreach and messaging system, when necessary.

Patient Signature: _____

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