Weber Chiropractic HIPAA Release Form

Name:_____ **Date of Birth:**_____

[ ] I authorize the release of information including the diagnosis, records, examination findings, and claims information. This information may be released to:

[ ] Spouse:_____

[ ] Child(ren):_____

[ ] Other: _____

[ ] I do not authorize release of my medical records to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Signed:_____ Date: _____

Witness: _____ Date_ _____