COUSINEAU CHIROPRACTIC LIFE CENTER
14550 KING RD RIVERVIEW, MI 48193

AUTHORIZATION FOR RELEASE OF RECORDS

I hereby authorize Cousineau Chiropractic Life Center to disclose to my insurance company or lawyer and all necessary information, which has been acquired by examination or other means of my physical or mental condition, and I release Cousineau Chiropractic Life Center of any consequences thereof.

XRAYS

Under the laws of the State of Michigan, x-rays are the property of this office. The amount paid by you or the insurance company are for interpretation. However, if needed, a copy can be made available.

ASSIGNMENT OF PAYMENT

My attorney and or insurance company are hereby requested and authorized to pay direct to Cousineau Chiropractic Life Center any monies due on account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay Cousineau Chiropractic Life Center the difference between the total amount of the charges and the amount paid by the attorney and or the insurance company. It is further understood that I, the undersigned, agree to pay Cousineau Chiropractic Life Center the full amount of the charges, should my condition be such that is not covered by my policy or if for any reason the insurance company refuses to pay the full amount of my claim. Cousineau Chiropractic Life Center will verify my insurance at the earliest date but it is my responsibility to know my insurance benefits.

NOTICE OF HIPPA

Section 8: Notice of Privacy Practices Acknowledgment Initial Uses Authorization Form
Cousineau Chiropractic Life Center P.C Effective 4-15-2003
By signing this form, you acknowledge that you were presented with a copy of the Notice of Privacy Practices of Cousineau Chiropractic Life Center PC. Our notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full. Our notice of Privacy Practices is subject to change. The most current version will be placed on display in the office at all times. You may obtain additional copies of our most current notice or ask any questions by contacting our office manager.

Print Patient Name:__________________ Signature of patient:________________________

Relationship to patient:_____________ Date:__________________