



Tri Star Spine and Sport Chiropractic

Dr. T.J. Keklak D.C., M.S., C.C.S.P.®

Release of Medical Information

This form is required, under HIPPA privacy regulations, to release your protected health information. We must have in writing your authorization as to whom we can release information.

I _____ (name) give my permission to Tri Star Spine and Sport Chiropractic to contact me at the following:

_____ **Home**

_____ **Work**

_____ **Answering Machine**

If, for some reason, the facility needs to relay my protected medical information, you can either leave a message with, or discuss the information with the following individual(s):

1. _____
2. _____
3. _____

Patient Name (print) _____

Patient Signature _____ **Date** _____