GOFFSTOWN CHIROPRACTIC CARE, PLLC
17A Tatro Drive, Suite 101
Goffstown, NH 03045
Telephone: (603) 384-1680
Fax: (603) 384-1679
www.goffstownchirocare.com

HIPAA Authorization Form for Family Members/Friends

I, _____, give permission to my health care services providers at Goffstown Chiropractic Care, PLLC to disclose and release my protected health information described below to:

Name(s):	*Relationship:*
_____	_____
_____	_____
_____	_____

Health Information to be disclosed:
My complete health record (including but not limited to diagnoses, diagnostic and lab tests, prognosis, treatment, account billing, account collections and scheduling of appointments for all conditions)

This health information may be used to enable the person(s) I authorize to know and understand my condition and my treatment and treatment options, for consultation and treatment, for claims payment, account billing and payment, scheduling of appointments for care, and any other care related reasons.

This authorization shall be effective until (check one):

- ❑ All past, present, and future periods, OR
- ❑ Date or event:_____

NOTE: You may revoke this authorization at any time by notifying your health care providers in writing.

_____
Name of the Individual Giving this Authorization

_____ _____
Signature of the Individual Giving this Authorization Date

"Consider chiropractic care first"