HIPAA RELEASE FORM

Name: _____ Date of Birth: _____

We are unable to discuss your treatment with anyone unless you give us written permission.

( ) I authorize the release of my information including diagnosis, records, images, and claim information. This information may be released to:

Please note: Certain treatments may require the patient to be sedated and a driver would be necessary. Your driver must be listed on this information release form prior to treatment.

( ) My general and/or referring physician Names: _____

_____

( ) Spouse Name: _____

( ) Child(ren) Names:_____

_____

_____

( ) Parent Name: _____

( ) Other Name: _____

( ) Information is not to be released to anyone.

This release of information will remain in effect until terminated by me in writing.

Signature: _____ Date: _____