CARMEN M. CLEMENSON, D.C.
CLEMENSON CHIROPRACTIC

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Authorization for Release of Information to Friends and/or Family

Many of our patients allow family members such as their spouse, parents, or others to call and request medical or billing information. HIPAA privacy laws restrict sharing patient information without the patient's consent. If you wish to allow your medical or billing information to be shared with family members, please indicate with whom this information can be shared

I authorize Clemenson Chiropractic to release my medical and/or billing information to the following:

1._____ Phone:_____ Relation:_____

2._____ Phone:_____ Relation:_____

3._____ Phone:_____ Relation:_____

Patient information

I understand I have the right to revoke this authorization at any time (in writing) and that I have the right to inspect or copy the protected health information to be disclosed. I understand that information disclosed to any above recipient is no longer protected by Federal or State law and may be subject top re-disclosure by the above recipient.

Name:_____ Date of Birth:_____

Signature:_____ Date:_____