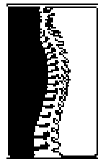

Bakke
Chiropractic Clinic

AUTHORIZATION TO DISCLOSE INFORMATION

I, ______________________________, hereby authorize Bakke Chiropractic Clinic SC to
(Patient name)

release information related to my medical treatment and/or financial account records to the

following person(s):

______________________________	______________________________
(Name of Authorized)	(Relationship to Patient)
______________________________	______________________________
(Name of Authorized)	(Relationship to Patient)

EXPIRATION DATE

Unless otherwise revoked, this authorization will expire on the following date: ______________

(I reserve the right to withdraw this authorization at any time by written, dated communication to Bakke Chiropractic Clinic SC.)

I understand that if the authorized recipient is not a provider, health plan, or clearinghouse required to comply with federal privacy standards, the information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards and my health information may then be disclosed by the recipient without obtaining any further authorization.

I have had an opportunity to review and understand the content of this Authorization form. By signing this Authorization, I am confirming that it accurately reflects my wishes.

Signature: ____ Date: ________________________

*If this authorization is signed by a representative of the patient, please complete the following:

Representative's Name: ____

Patient is: ____ Minor ____ Incompetent ____ Disabled ____

Deceased Legal Authority: ____ Parent of Minor ____ Legal Guardian Power of Attorney ____ Next of Kin