

Patient Case# _____

RELEASE OF PROTECTED PATIENT INFORMATION

PATIENT NAME: _____

This notice serves as an official authorization for the release of protected information regarding the treatment of the aforementioned patient. I, hereby, allow those individuals employed by Crafton Chiropractic, Inc. to release any and all information affiliated with the treatment rendered to me. I accept full liability regarding release of such information to the listed individuals.

NAMES OF AUTHORIZED INDIVIDUALS:

HIPAA NOTICE RECEIPT

By signing below, I acknowledge that I have received and reviewed the HIPAA Patient Consent notice and all of my questions have been answered to my satisfaction in language that I can understand.

Name of Patient (Printed)

Signature of Patient

Signature of Legal Representative
(e.g., Attorney-In-Fact, Guardian,
Parent if a minor)

Relationship

Date Signed _____ / _____ / _____

Witness: _____