Consent to Release Information

Please print this page, complete the form, and bring to your appointment

I hereby consent to the use or disclosure, by Unfried Chiropractic, of my individually identifiable health information/ protected health information described below. I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information.

☐ **I consent to the disclosure and the use of the Health Information described above to the following person(s) or organization(s) as noted below:**

Please list any family members, guardians, friends, or legal counsel with whom we are allowed to discuss your treatment or billing issues. Dependents over the age of 18 must give consent for release of information; they may indicate "unrestricted" and name one or both parents. The fact that they are over 18 does require us to "protect" their health information and does require consent for release of information. Information regarding dependents under 18 can only be released to either parent or legal guardian (unless there is a court order restriction) and requires parental consent for release other than as allowed by law.

Relationship ______________________________

Relationship ______________________________

Relationship ______________________________

Relationship ______________________________

☐ **I *DO NOT* want my information shared with anyone other than myself**

Comments

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Print Name ______________________________

Parent Signature ______________________________

Parent/Guardian if under 18 ______________________________

Relationship ______________________________ **Date** ______________________________