**HIPAA AUTHORIZATION**

In compliance with Chiropractic and Acupuncture Wellness Center (CAWC) this form will allow you to designate an individual(s) to whom CAWC may disclose your protected health information. This may include individually identifiable information related to past, present or future appointment, medical or financial information. If you do not want to designate an individual(s) to receive your protected health information, indicate “none” below.

Patient Name:

Date of Birth:

Address:

City: \_\_\_\_\_\_\_\_\_\_\_\_State: Zip: \_\_\_\_\_

Telephone Number: (\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I do hereby authorize CAWC to disclose protected health information to the following:

**1.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_

Name / Relationship to patient / Telephone number

**2**. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_

Name / Relationship to patient / Telephone number

**3.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_

Name / Relationship to patient / Telephone number

By signing below I acknowledge that I have had full opportunity to read and consider the content of this authorization and understand that my protected health information may be disclosed to the individual(s) listed above. I understand that designating the individual(s) listed above does not exclude CAWC from disclosing my protected health information as outlined by CAWC.

I understand that I have the option to revoke this authorization at anytime at which time I can execute a new authorization. I also understand that unless revoked in writing by completing a new authorization form, this authorization will remain in effect until I choose to revoke it.

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Patient Signature / Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Personal Representative (Relationship to Patient) / Date