Authorization for the Disclosure of Private Health Information

I, _____, authorize the Prince William Chiropractic Clinic to release my private health information as necessary to physicians involved in my care, my insurance company, and others necessary for the purpose of Treatment, Payment, or Operations. I further authorize the Prince William Chiropractic Clinic to discuss my health or my account with the following individuals:

_____ Spouse: _____

_____ Family Member: _____

_____ Other: _____

Signature of Patient / Responsible Party	Date
Printed Name of Patient / Responsible Party	Reserved for Local Use (Staff Initials)