HIPAA DISCLOSURE FORM

I, ____________________ have received a copy of Drees Chiropractic's Notice of Privacy Practice.

Name of Patient ____

Address of Patient ____

____

Please complete each entry below and circle the best number to reach you:

Home phone _____________ Cell phone _____________ Work phone ______________

Email address ____

DOB _____/______/______

May we identify ourselves over the phone? Yes _____ No _____

May we leave a message? Yes ______ No ______

I, the Patient, hereby authorize the doctor and/or staff listed above to release my medical information (appointments, lab/x-ray, diagnosis, treatments) via mail, telephone, fax or e-mail to the following family members:

Name:	Telephone:	Relationship:
________________________________	_____________	__________
________________________________	_____________	__________
________________________________	_____________	__________

Signature of Patient ________________________________ Date _________________

Signature of Witness ________________________________ Date _________________