Askeland Chiropractic & Acupuncture P.C.

HIPAA RELEASE OF INFORMATION
AUTHORIZATION FORM

NAME OF PATIENT: _____
DATE OF BIRTH: _____

At my request, I authorize Askeland Chiropractic & Acupuncture to disclose Protected Health Information to the following person(s):

_____
Relationship to Patient: _____

_____
Relationship to Patient: _____

_____
Relationship to Patient: _____

I authorize the following Protected Health Information to be released **(check which option(s) apply)**:

- o All Information Requested
- o All Claims Information
- o Explanation of Benefits Information
- o All Payment Information

*I understand that I may revoke this authorization at any time by giving notice **in writing** to Askeland Chiropractic & Acupuncture.*

Patient Signature: _____
Date: _____