

Authorization to Release and Disclosure Protected Health Information

In accordance the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA):

I, or my authorized representative, request that health information regarding my care and treatment be released to my insurance company(ies) and their agents for the purpose of determining insurance benefits and obtaining payment/ billing for services rendered. This authorization will remain in effect while seeking “active care” at Gibbons Holistic Chiropractic & Wellness Centre.

No personal health information will be released to other treating physicians, family, and or friends unless requested and authorized by you or your authorized representative.

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Signature of Patient, Parent/ Guardian or Personal Representative

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Please print name of Patient, Parent/ Guardian or Personal Representative

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Relationship to Patient

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Date