***HIPPA – Health Information Portability and Accountability Act***

***Release Information Form for***

***Healing Waves Chiropractic, LLC***

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_/\_\_\_\_/\_\_\_\_\_**

***Release of Information:***

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to **(please check ALL that apply)**:

[ ] Spouse - Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Child(ren) - Names:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Other- Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Information is not to be released to anyone other than for insurance purposes and when required by law.

This ***Release of Information*** will remain in effect until terminated by me in writing.

 I wish to be contacted in the following manner (check all that apply):

\_\_\_\_Home Telephone \_\_\_\_Written Communication

\_\_\_\_Leave detailed message at home \_\_\_\_Mail to Home Address

\_\_\_\_Leave message with call back number only at home \_\_\_\_Mail to Alternate Address

\_\_\_\_Leave detailed message at work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Leave message with call back number only at work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Photograph Agreement:***

Photographs are required for our postural analysis program and generated personalized report. Postural analysis is an excellent tool for tracking progress while under care. Any photographs will never be released without express written permission. **Please check one of the following.**

\_\_\_ I allow postural analysis photographs \_\_\_ I **do not** allow postural photographs to be taken

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

Witness:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_/\_\_\_\_/\_\_\_\_\_\_