LONGNER
Chiropractic

Medical Information Release Form

(HIPAA Release Form)

Name: _____ **Date of Birth:** ____/____/____

Release of Information

I hereby authorize:

Longner Chiropractic
3712 Hwy 95 Ste 8
Bullhead City, AZ, 86442

To release my medical records and x-rays including the diagnosis, examination rendered to me and claims information to:

- ☐ Self
- ☐ Spouse_____
- ☐ Child(ren)_____
- ☐ Other_____

☐ Information is not to be released to anyone.

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

Signed: _____ Date: ____/____/____