HIPAA Release Form

I, the undersigned, being of full age, do hereby consent pursuant to the security requirements of the Federal Health Insurance Portability and Accountability Act (HIPAA) to allow the below named healthcare professionals to transmit my records, or the records of a minor child of whom I am the parent, guardian, or legally appointed representative by fax, email, or any other electronic means at their discretion, and as they see fit, to obtain reimbursement from my insurance carrier, from me, or to communicate with my attorney, carrier, or other party as required for the administration of my or the aforementioned minor child's affairs. Furthermore, I give the below named healthcare professionals permission to post my name in their office as a source of referrals, with my written consent.

To my carrier: You may release any information regarding my or the aforementioned minor child's records to the below named healthcare professionals and clinic, and I herewith demand a copy of any independent examination reports automatically be forwarded to them, for which I accept responsibility for any reasonable charge applicable thereto, pursuant to law.

If you understand and accept the foregoing, please sign on the line provided below:

Signed: _____ Date: _____

Print Name: _____

Name of Minor Child (if applicable): _____

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