PATIENT INFORMATION RELEASE CONSENT FORM

Nielsen Chiropractic Health Center is requesting _____ (patient's name) to provide consent to release confidential healthcare information to:

- Insurance Company(ies) _____
- Attorney _____
- Family Members, Friends, and/or Emergency Contact:_____

  _____
- Employer or School:_____

For the purpose of patient care and the billing of patient care when providing needed healthcare treatment, to obtain payment for healthcare services, for healthcare operations, or to determine eligibility for employment.

CONDITIONS:

- The patient has the right to request that this facility maintain his/her healthcare information as confidential.
- The patient has the right to review the facility's policy for regarding the use of confidential patient healthcare information without the patient's consent.
- This facility reserves the right to either honor or dismiss the patient's request to limit the use of the patient's healthcare information.
- Should this facility agree to the patient's restrictions on providing confidential healthcare information, the request will be maintained by this facility.
- The patient has the right to revoke this consent at any time. Revoking of this consent must be made in writing, signed and dated.
- This consent is between Nielsen Chiropractic Health Center and _____ (patient's name). No other individuals/organizations have permission to obtain the patient's confidential healthcare information under this consent.
- This consent form will be stored at this facility.

SIGNATURES:

Patient: _____ Date: _____

Facility Representative: _____ Date: _____