



MEDICAL AUTHORIZATION

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The undersigned person hereby consents to, and by this Authorization or any photocopy hereof authorizes Clyne Chiropractic & Wellness, L.L.C. the release of his/her medical information, i.e. any and all medical reports, histories, findings, prognosis, bills and other documents relating to the medical treatment in our office to insurance carriers, law offices or any other third party entities, when requested.

The undersigned person understands and hereby acknowledges that the information above, or certain portions thereof, may be protected from disclosure without this signed Authorization by Federal and State privacy and confidentiality laws.

This authorization is subject to revocation with respect to all or any particular records at any time by the undersigned person in writing, delivered to the holder of such records, except to the extent that action has already been taken in reliance upon this Authorization.

Date: _____ Patient: _____

If consent is necessary by a parent, guardian or authorized representative:

Relationship to Patient