CHIROPRACTIC CLINICS INC.

AUTHORIZATION TO PROVIDE INSURANCE COVERAGE

My Insurance carrier is authorized and requested to release to Chiropractic Clinics, Inc coverage information, including but not limited to percentage of coverage, deductible limits and amounts of coverage used and remaining benefits available under my coverage. Further by my signature below, I hereby release my insurance carrier of any consequences thereof.

AUTHORIZATION TO RELEASE INFORMATION

I hereby, authorize Chiropractic Clinics, Inc., to release a copy of my patient records and/or x-rays containing protected health information to ______________________________
Additionally, I authorize release to my insurance carrier or its representative, my attorney, state agency, or legal guardian, any and all medical information as deemed appropriate, including but not limited to, a full report of my examination, diagnosis, treatment, prognosis, etc., office notes outlining my care, and an itemized statement of the services rendered to me with regard to my accident, injury or condition in order to process any claims that I may have in connection with such accident or injury, and to pay charges incurred by me as a result of the professional services that I have received. Further, by my signature below, I hereby release Chiropractic Clinics, Inc. of any consequence thereof. This authorization is given pursuant to Florida Statute 456.057 and HIPAA regulations. I understand that Florida Statue 456.057(10) makes clear that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical record without the expressed written consent of the patient or the patient's legal representative.

REASSIGNMENT OF TREATMENT

I, the undersigned hereby advise my insurance carrier and Chiropractic Clinics, Inc. that I have discontinued treatment with any and all former chiropractors. As I continue to require treatment, I have elected to receive all future chiropractic care, in relation to this accident from Chiropractic Clinics, Inc.

AUTHORIZATION FOR MEDICAL INFORMATION

This authorizes the physicians, hospitals, medical attendants and attorneys to furnish all complete medical reports, records and information to Chiropractic Clinics, Inc.

I the undersigned patient agree that a photocopy of this authorization may be used in lieu of the original.

I have read, and fully understand the above:

______________________________ ______________________
(Patient Name - Representative Signature) (Date)

______________________________ ______________________
(Patient Name - Representative Print) Patient's Date of Birth