

Authorization to Disclose

To: ChiroCare Plus, P.C.
Dr. Dennis J. Gesualdi, D.C.

I, _____ of _____,
(Patient name) (Patient's address)

hereby grant my permission for Dr. Gesualdi and his staff to speak with _____

my authorized agent, on my behalf regarding my care and treatment received in this office, including questions regarding my insurance coverage and benefits, and any account balance I may have.

I acknowledge and understand my rights to privacy and confidentiality regarding my personal healthcare information are protected under the federal Health Insurance Portability and Accounting Act of 1996 (HIPAA), as noted by my signature on ChiroCare's Privacy Policy form presented to me prior to examination and treatment in this office. I further understand that I may revoke this authorization at any time in the future, by notifying ChiroCare and Dr. Gesualdi in writing of my request.

I understand that by authorizing Dr. Gesualdi or his staff to disclose this information solely to the above named party, that responsibility for the disclosed information when provided becomes that of myself and my named agent. ChiroCare cannot be held liable for the confidentiality of the disclosed information once released from this office.

Executed this _____ day of _____, in the year _____.

Signature of Patient

Signature of Witness

Printed Name

Printed Name