Dr. Brian S. Dixon,

CHIROPRACTIC CLINIC WEST

Ninety Berkshire Avenue
Springfield, Massachusetts 01109
(413) 739-7968

WAIVER FOR RELEASE OF INFORMATION

PATIENT NAME: ______________________
ADDRESS: ______________________
____
PHONE: ______________________
S.S.NUMBER: ______________________
DATE OF BIRTH: ______________________

This authorization, photocopy, or facsimile hereof, will hereby give permission for the release of all information you may have regarding my condition or pertaining to my health history to the above named doctors.

HIPPA FACSIMILES: The personal health information contained herein is privileged and highly confidential. It is intended for the exclusive use of the person to whom it is addressed and is to be used only to aid the recipient in providing healthcare services to this patient. Any other use or disclosure is a violation of Federal Law (HIPPA) and will be reported.

DATE ______________

SIGNATURE OF PATIENT
OR GUARDIAN ______________________________