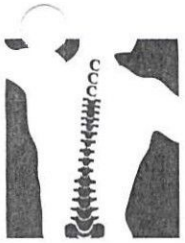

Crossroads Chiropractic Clinic

Dr. Glenn A. Brenneman, Jr.
Dr. Norman P. Bedillion

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulation, and that it may be redisclosed by the recipient.

PATIENT NAME:_____ **DOB:**_____

ORGANIZATION PROVIDING THE INFORMATION:_____

ORGANIZATION OR PERSON RECEIVING THE INFORMATION:_____

_____

SPECIFIC DESCRIPTION OF INFORMATION DISCLOSED:

( ) Treatment records (areas) _____ (dates) _____

( ) X-Ray report (areas) _____ (dates) _____

( ) MRI report (areas) _____ (dates) _____

( ) CT report (areas) _____ (dates) _____

( ) Other (info) _____ (areas) _____ (dates) _____

PURPOSE OF DISCLOSURE: _____

You must read and initial the following statements:

1. I understand this Authorization will expire on ____/____/____ (mm/dd/yy) or on the following event _____. **INITIALS:** _____
2. I understand that I may revoke this Authorization at any time by notifying Crossroads Chiropractic Clinic in writing, but if I do, it will not have any effect on any actions Crossroads Chiropractic Clinic took before they received the revocation. **INITIALS:** _____

_____ _____
Signature of Patient or Representative Date

_____
Relationship to Patient

You may refuse to sign the Authorization. We cannot condition treatment on your signing this Authorization.

156 W. Chestnut Street, Washington, PA 15301
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