The new federal privacy laws (HIPAA) were enacted to protect patient privacy. These laws prevent anyone from having access to your healthcare information without your prior authorization. Because of these laws, we cannot tell anyone any information regarding your healthcare at our office – your diagnosis, treatment, recommendations, appointment times, etc. – without your prior authorization. While this is certainly important, the application of these laws often causes inconvenience for the patient, as concerned loved ones, friends, etc. often call the office to check appointment times, ask questions with regards to the diagnosis or treatment, etc.

For your convenience, please list the names of people whom you authorize to have your healthcare information and their relationship to you. This could include parents, spouses, children, siblings, relatives, friends, co-workers, etc.

I, ___________________________, hereby authorize the following people to have access to my healthcare records and information at Willis ChiroMed. I fully understand that, by doing so, he/she/they will be privy to any and/or all of my health information that has been discussed or otherwise presented to me by the doctor and staff and/or any information contained within their records of me. I give full consent to his/her/their access to my health information. I understand that this authorization for this person(s) will remain in effect indefinitely into the future unless I revoke it. I also understand that I can revoke this authorization at any time, but must do so in writing so that it can be kept in my permanent record.

Name	Relationship to Patient
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

______________________________ ______________________________
Patient Signature Date

______________________________ ______________________________
Witness Signature Date