AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize Sanders Chiropractic to release all medical information (including but not limited to psychiatric condition, sickle cell anemia, alcohol and drug abuse also HIV or communicable diseases) requested by my health insurance carrier, Medicare or any other third party payer. I authorize Sanders Chiropractic to release all medical information to my referring physician and my primary (family) physician. I authorize Sanders Chiropractic to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy, I direct the insurance company or health plan administrator to release such information to Sanders Chiropractic.

I agree that these provisions will remain in effect until I provide written revocation to Sanders Chiropractic.

Signature of patient or guardian: _____ date: _____