Please read carefully and sign below:

- I give permission to my AudigyCertified™ practice to release information, verbal and written (contained in my medical record and other related information), to my insurance company, rehab nurse, case manager, attorney, employer, related healthcare providers, assignees, and/or beneficiaries and all other related persons. Information without patient identifiers may be used for quality purposes.

  _____ ***Initial to refuse permission to release records.***

- Please List any Persons or Providers you would like reports/updates to be sent to:

_____

_____

- I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of this office. (If you would like a copy of this Policy, please ask the front desk)

- I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services or purchases rendered.

- I have read all the information on this sheet, completed the above answers, and certify this information is true and correct to the best of my knowledge and hereby give my AudigyCertified practice permission to treat my concerns.

I have read and understand all the above information.

_____

Patient Signature (A copy of hits signature is as valid as the original) Date

_____

Signature of Parent or Guardian Date