Release of Confidential Patient Information

Nicole Holton, DC, is dedicated to preserving your "Protected Health Information" (PHI). We are required by law to protect your health information and to provide you with notice describing how your medical information may be used and disclosed and how you can access this information.

By signing this form you authorize the persons listed below to have access to any of your medical and/or billing information retained by Dr. Holton's office. This authorization is good for one year unless you revoke authorization in writing.

Authorized Persons:	Circle one or both to authorize release:	
Name:_____ relationship:_____	medical records	billing
Name:_____ relationship:_____	medical records	billing
Name:_____ relationship:_____	medical records	billing
Name:_____ relationship:_____	medical records	billing

Patient's signature:_____ Date:_____

Print name:_____