Platte Valley Chiropractic
Functional Medicine & Acupuncture

Dr. Trenton L. Talbitzer, D.C., D.A.B.C.I
Board Certified Chiropractic Internist

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Authorization to Release Healthcare Information

Patient's Name: _____ Date of Birth:_____

I give permission for Dr. Trenton Talbitzer D.C., D.A.B.C.I, and Platte Valley Chiropractic staff members, to discuss my healthcare, and healthcare services with the following people.

Name:_____ Relationship;_____

Phone #:_____

Name:_____ Relationship;_____

Phone #:_____

Name:_____ Relationship;_____

Phone #:_____

_____ I do not wish to share my health information with anyone at this time.

I have the right to revoke this authorization at any time by providing written notice. I also understand that I can change the names on this list at any time, but I would need to do that in written form that would be placed in my medical file. This authorization is valid from the date of signature and will not expire until any changes need to be made.

_____ _____

Patient Date Signed