CHIROPRACTIC
HEALTH CLINIC OF HUNTSVILLE

DR. HUNTER P. LEE
806 Governors Drive SW, Suite 102
Huntsville, AL 35801
(256)801-7731

AUTHORIZATION TO RELEASE INFORMATION

I authorize *Chiropractic Health Clinic of Huntsville* to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered and hereby release him/her of any consequences thereof. I agree that a photostatic copy of this agreement shall serve as the original.

_____ _____
Date Patient/Insured Signature

NOTICE OF ASSIGMENT

I hereby authorize and direct payment of any medical and surgical expense benefits allowable to *Chiropractic Health Clinic of Huntsville* as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the assignee. I agree that a photostatic copy of this agreement shall serve as the original.

_____ _____
Date Patient/Insured Signature

AUTHORIZATION TO RELEASE INFORMATION TO SPECIFIED PARTIES

I hereby authorize you to release any information including the diagnosis and records of treatment or examination rendered to me for all care during at Chiropractic Health Clinic to the following listed:

Name:	Relation to Patient:
Name:	Relation to Patient:
Name:	Relation to Patient:

_____ _____
Date Patient/Insured Signature

Staff Signature_____ Date_____