PLEASE FILL OUT IF YOU HAVE AN ATTORNEY

I _____ hereby authorize Joseph P. Hornberger, M.S., D.C., P.A. of Hornberger Chiropractic Center to release any of my patient records, x-rays, or medical billing that may contain protected health information to my attorney _____. This authorization is given pursuant to Florida Statute 456.057 and HIPPA regulations. I understand that Florida Statute 456.057 (10) makes clear that my attorney can not receive any of my records without my written consent.

Patient's Signature_____

Patient's Date of Birth_____/_____/_____

Patient's Legal Guardian if Patient is Minor_____

Date Signed_____/_____/_____