AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize any licensed physician, hospital, clinic, or health professional or facility to release information from my patient records,

_____ (patient's name)

To the Chiropractic Physicians'' Board of Nevada, its employees or agents.

I understand that this release is granted subject to the following conditions:

1. This information will be used only in the conduct of authorized responsibilities of the Chiropractic Physicians' Board of Nevada.

2. All information may be released. This includes history, mental or physical condition, diagnosis, prognosis and treatment, laboratory reports, diagnostic imaging and billing data and;

3. This release shall be valid for one year.

_____ _____
Date Signature of Patient

_____ _____
Date Signature of Parent or Guardian (if needed)

_____ _____
Date Signature of Witness