

**Authorization To Use And Disclose Protected Health (And Other) Information**

I authorize Kimberly DeAlto, D.C. to release a copy of my Protected Health (and/or other) information to:

Recipient: \_\_\_\_\_

For the purpose of: \_\_\_\_\_.

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_