ACUPUNCTURE/DRY-NEEDLING

NATUROPATHIC MEDICINE

Authorization to Release Health Information

Individual Information

Patient Name: _____ **Date of Birth:** _____

Information may be disclosed by:

Name of provider, or organization releasing information: _____

Address: _____**Suite/Apt#:** _____

City: _____ **State:** _____ **Zip:** _____

Fax: (_____) _____ **Office Phone #:** (_____) _____

Information may be disclosed to:

Name of organization or person to receive information: _____

Address: _____**Suite/Apt#:** _____

City: _____ **State:** _____ **Zip:** _____

Fax: (_____) _____ **Office Phone #:** (_____) _____

What kind of information do you want disclosed? (Check box, copy fees may apply)

☐ All records from the last 2 years of visits

☐ Information from date_____/_____/_____ to date_____/_____/_____

☐ Specific information (specify): _____

☐ Others: _____

Authorization

Information released may include information regarding the testing, diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, chemical dependency or mental/psychiatric illness. I give specific authorization for this information to be released.

_____ **initial**

Rights

Generally, Balance and any other entity covered by the Health Insurance Portability and Accountability Act of 1996, may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. I may revoke this authorization in writing. Once the information I have authorized to be disclosed is disclosed, it may no longer be protected under health information privacy laws. If I revoke my authorization, it will not affect any actions already taken by Balance based upon this authorization.

_____ _____

Patient or Guardian, or Authorization Representative **Date**

(Documentation may be required to prove authority to sign on behalf of the patient)