Ageless-Acupuncture

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Authorization for Ageless-Acupuncture LLC to Receive Health Information

This authorization must be written, dated and signed by the patient or by a person authorized by law to give authorization for the patient.

Health Record #____________________ Social Security #: _______ - _____ - _________ DOB: _____ / _____ / _______

I authorize:

____
Name of Provider/Clinic/Hospital

____
Street Address

____
City, State, Zip Code

Please send my medical information to:

____
Name of Person to Receive Information

At: Ageless-Acupuncture LLC

To use and disclose a copy of the specific health information described below regarding:

____
Patient Name

Consisting of (describe information to be used/disclosed):____

____

The information will be used on my behalf for the following purposes (describe purpose of each use/disclosure, or write *"at the request of the individual"* if this authorization is initiated by patient and patient does not, or elects not to, provide a statement of purpose): ____

____

____

This authorization will expire on the earlier of ________________ (date 180 days from date of signing), or the end of the period reasonably needed to complete the disclosures for the above-described purpose.

Your health care and payment for that health care cannot be conditioned upon receipt of this signed Authorization unless your health care or treatment is for the purpose of research.

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on the Authorization. If you wish to revoke this Authorization, please send a written statement to: *The Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201* which identifies the date you signed this Authorization, the recipient of the information identified in the Authorization, and states that you are revoking this Authorization.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed as a result of this Authorization may be subject to re-disclosure by the recipient, and no longer be protected under federal law.

____ ____________________________
Patient Signature Date

____ ____________________________
Signature of Patient's Personal Representative (if applicable) Description of Personal Representative's Authority

I understand that certain information in these records cannot be used/disclosed without specific authorization because of federal or state laws. By initialing the spaces below, I specifically authorize the release of the following confidential information for use by Ageless-Acupuncture LLC.

_______HIV/AIDS Records

_______Drug/Alcohol diagnosis, treatment, or referral information

_______Mental Health treatment information

_______Genetic Testing Information