Authorization for the Use and Disclosure of Health Information

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Name of Patient ______________________________

Date of Birth ______________ SSN ______________ (optional)

I. My Authorization: I authorize the following using or disclosing party:

____

to use or disclose the following health information: (check one)

☐ - All of my health information

☐ - My health information relating to the following treatment or condition: ______________

☐ - My health information covering the period of (insert dates): ______________ to ______________

☐ - Other ______________________________

The above party may disclose this health information to the following recipient:

Name (or title) and organization ______________________________

Address ______________________________

City ______________ State ________ Zip ______________

Phone ______________ Fax ______________ Email ______________

The purpose of this authorization is: (check all that apply): ☐ - At my request ☐ - Other

Select delivery method: ☐ - email* ☐ - US Mail ☐ - fax ☐ - pick-up at the clinic

This authorization ends: (check one) ☐ - On (date) ______________ - *or* -

☐ - When the following event occurs ______________________________

II. My Rights: I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature ______________________ Date ______________ Phone ______________

* Please keep in mind that communications via email over the internet are not secure. Although it is unlikely, there is a possibility that information you include in an email can be intercepted and read by other parties besides the person to whom it is addressed.

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If the information you are requesting to be disclosed is not about you or your minor child, please complete the section below. If you are a legal representative of the person whose information is to be disclosed, you must provide documentation proving your legal authority to request this information. (For example, guardianship papers, power of attorney, health care surrogate form, letters of representation.)

Legal Representative (Signature) ______________________________

Legal Representative (Print Name) ______________________________

Relationship of Legal Representative ____________________ Date __________

III. Additional Consent for Certain Conditions:

This medical record may contain information about **physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment**. It may also contain information concerning **HIV testing and/or AIDS diagnosis or treatment**.

☐ - I consent to have the above information released.

☐ - I do not consent to have the following information released (check all that apply):

☐ - Alcohol & Drug Information/Treatment ☐ - Psychiatric/Behavioral Health ☐ - AIDS/HIV/ STD Testing/Results

Signature of Patient or Authorized Representative ______________________________

Date ______________

IV. Payment: There will be fees associated with most record requests as outlined below.

☐ - Check here if you require a call for fee approval prior to us processing your records.

Instructions for completing this form

Complete and return to: *Academy for Five Element Acupuncture*, c/o *Clinic Records*, 305 SE 2nd Avenue, Gainesville, FL 32601, fax 352.337.2535, email clinic@acupuncturist.edu. If the signer is a legal representative, guardian, health care surrogate or has power of attorney, documentation of the representative's legal authority to act on behalf of the individual whose information is to be disclosed must be attached with the authorization form. Our average turnaround time for processing requests is seven business days.

You may be charged for copies of patient records as allowed by law. Charges may include sales tax and actual postage, and, except for non-paper records, may not exceed $1 per page. Fees are waived when PHI is released to a health care provider for treatment purposes.

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