AUTHORIZATION FOR USE OR RELEASE OF HEALTH INFORMATION

NOTICE: This medical record information release (HIPAA) form allows a patient to give authorization to a 3rd party and access their health records. The release also allows the added option for healthcare providers to share information. A medical release form can be revoked or reassigned by the patient.

I. THE PATIENT. 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.

Patient's Full Name: _____

Date of Birth: _____,20____ Phone: _____

Address: _____

_____

II. AUTHORIZATION. This authorization allows the healthcare provider(s) named below to release confidential medical information and records. I authorize LIFE GIVING ACUPUNCTURE INC. 26700 Towne Centre Dr., Suite 250 Foothill Ranch CA 92610 ("Authorized Party") to use or disclose the following: (must check one)

☐ - All of my medical-related information.

☐ - My medical information ONLY related to: (check all that apply)

☐ Billing Statement	☐ Health Evaluation
☐ Physical Exams	☐ Progress Notes
☐ Other:	

☐ - Other: _____.

Specify Date/Time Period for the information (MM/DD/YYYY): from _____, 20____ to _____, 20____.

Hereinafter known as the "Medical Records (=Protective Health Information)."

III. DISCLOSURE. The Authorized Party has my authorization to disclose Medical Records to:

☐ - Any party that is approved by the Authorized Party (LIFE GIVING ACUPUNCTURE INC).

☐ - ONLY the following party:

Name: _____

Address: _____

_____

Phone: (_____) _____-_____ Fax: (_____) _____-_____

E-Mail: _____

IV. PURPOSE. The reason for this authorization is: (must check one)

☐ - **General Purpose**. At the request of the patient.

☐ - **To Receive Payment**. To allow the Authorized Party to communicate with me for marketing purposes when they receive payment from a third party.

☐ - **To Sell Medical Records**. To allow the Authorized Party to sell my Medical Records. I understand that the Authorized Party will receive compensation for the disclosure of my Medical Records and will stop any future sales if I revoke this authorization.

☐ - **Other (State reason)**: _____.

V. TERMINATION. This authorization will terminate: (must check one and state any applicable date or event)

☐ - Upon sending a written revocation to the Authorization Party.

☐ - On the following date: _____, 20____.

☐ - Other: _____.

VI. ACKNOWLEDGMENT OF RIGHTS.

I understand that I have the right to revoke this authorization, in writing and at any time, except where uses or disclosures have already been made based upon my original permission. I might not be able to revoke this authorization if its purpose was to obtain insurance. I understand that uses and disclosures already made based upon my original permission cannot be taken back. I understand that it is possible that Medical Records and information used or disclosed with my permission may be re-disclosed by a recipient and 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 Medical Records 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 of Patient: _____ Date: _____

Print Name: _____

(IF THE PATIENT IS UNABLE TO SIGN, USE THE SIGNATURE AREA BELOW) The patient is unable to sign due to: (must check one)

☐ - **Being a Minor**. Patient is ____ years old and considered a minor under state law.

☐ - **Being Incapacitated**. Patient is incapacitated due to: _____.

☐ - **Other**: _____.

Signature of Legal Representative: _____ Date: _____

Print Name: _____ Phone Number: _____

Relationship to Patient: ☐ Parent ☐ Spouse ☐ Guardian ☐ Other: _____.

ADDITIONAL CONSENT FOR CERTAIN CONDITIONS

I. SENSITIVE INFORMATION. This medical record may contain information about physical or sexual abuse, alcoholism, drug abuse, substance abuse, genetic testing results, sexually transmitted diseases, abortion, or psychiatric/mental health treatment. Separate consent must be given before this information can be released. (must check one)

☐ - **I consent** to have the above information released.

☐ - **I do NOT consent** to have the above information released.

Signature of Patient: _____ Date: _____

Print Name: _____

II. HIV/AIDS. This medical record may contain information concerning HIV testing and/or AIDS diagnosis or treatment. Separate consent must be given to have this information released. (must check one)

☐ - **I consent** to have the above information released.

☐ - **I do NOT consent** to have the above information released.

Signature of Patient: _____ Date: _____

Print Name: _____

MY RIGHT

I understand this authorization is voluntary. I have been advised of my right to receive a copy of this authorization.