ACUPUNCTURE AND CHINESE MEDICINE CENTER

7600 Parklawn Avenue, Suite 321, Edina MN 55435 • Phone: (952) 820-0877

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ Telephone: _____

_____

Information to be Released From:

Doctor/Clinic Name: _____

_____

Address: _____

_____

Phone Number: _____

Information to be Released To:

Acupuncture and Chinese Medicine Center

7600 Parklawn Avenue, Suite 321
Edina, MN 55435
Phone Number: 952-820-0877

Information to be Disclosed:

☐ Entire Medical Record
☐ Progress Notes
☐ IVF Stimulation Summary Sheet
☐ Lab Reports (including Semen Analysis)

For the following date(s) of treatment: _____

☐ Other (Specify): _____

Information to be Released By:

☐ Fax: _____ ☐ Mail ☐ Phone

All records pertaining to psychiatric/mental health, chemical dependency, and/or HIV/AIDS related illness/testing will be released unless otherwise indicated by a checkmark here: _____

Please indicate any restrictions. (Specify) _____

The information is being requested for the following purpose:

☐ Continued Care ☐ Insurance ☐ Legal ☐ Personal Use ☐ Other: _____

- I understand I may revoke this authorization by written request at any time to the address listed at the top of this form. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- I understand that this authorization will automatically expire one year from the date of my signature.
- I understand that once information is released pursuant to this authorization, it may be subject to re-disclosure by the recipient to another third party.
- I understand there may be a charge associated with the Release of Information Services rendered. There is no charge for release of information to other health care facilities.

_____ _____

Signature of Patient/Legal Guardian Date

_____

Relationship if not Patient