EMPEROR'S COLLEGE | Community Acupuncture Clinic

1807-B Wilshire Blvd
Santa Monica, CA 90403
310.453.8383

AUTHORIZATION TO RELEASE INFORMATION

Section A: Must be completed for all authorizations

I hereby authorize the use of disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient Name: _____ **Staff Signature:** _____

Persons/organizations providing the information:

_____
_____
_____

Person/organizations receiving the information:

_____
_____
_____

Specific description of information (include dates):

_____
_____
_____
_____
_____
_____

Section B: Must be completed only if a health plan or a health care provider has requested the authorization

1. The health plan or health care provider must complete the following: ***a.*** What is the purpose of the use of the disclosure? _____
   _____
   b. Will the health plan or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes ☐ No ☐

2. The patient or the patient's representative must read and initial the following statements: ***a.*** I understand that my health care and the payment for my health care will not be affected if I do not sign this form. Initials: _____ ***b.*** I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it. Initials: _____

Section C: Must be completed for all authorizations

The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire on __ __/__ __/__ __ __ __ (DD/MM/YYYY) Initials: _____
2. I understand that I may revoke this authorization at any time by notifying the practice in writing, but if I do it won't have any affect on any actions they took before they received the revocation. Initials: _____

_____

Signature of patient or patient's representative *(form MUST be completed before signing)* Date

Printed name of patient's representative: _____

Relationship to the patient: _____