ROANOKE COMMUNITY ACUPUNCTURE, PLC.
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

NAME:_____ DOB: ___/____/____ SOCIAL SECURITY #: ___/____/____

Primary PHONE: _____/_____/_____ Email: _____
Mailing Address:
_____

I authorize Roanoke Community Acupuncture PLC to release the following information:
- ○ Treatment Notes
- ○ Medical Intake and History Forms
- ○ Payment History

PURPOSE OF DISCLOSURE:
- ○ Personal Records
- ○ Medical Followup with Health Care Professional
- ○ Insurance or Legal
- ○ Other (please specify): _____

BY:
- ○ **EMAIL ONLY**
- ○ **POSTAL MAIL**
- ○ **EMAIL & POSTAL**

NAME: _____

EMAIL: _____

POSTAL ADDRESS: _____

PHONE: _____

MY SIGNATURE BELOW INDICATES THAT I ACKNOWLEDGE, UNDERSTAND and CONSENT TO THE FOLLOWING:

- ○ If the person or agency that receives my information is not a health care provider or health plan covered by the HIPPA privacy regulations, the information described above may be redisclosed and is no longer protected by these regulations.
- ○ My written notification is necessary to cancel this authorization. I am aware that my cancellation will not be effective as to disclosures already made in reference to this authorization.
- ○ This released information may contain, alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information.

X_____ (PRINTED NAME)

X_____ _____/_____/_____
PATIENT OR LEGAL GUARDIAN SIGNATURE DATE

Sent: _____/_____/_____ by _____