**AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION**

**Patient Information**

**Name:**

**Address:**

**City: State: Zip:**

**Date of birth: Primary Phone: Cellular phone:**

**Information Requested to be Released**

* **Chinese medicine records (A copy will be made and sent)**
* **Date Range for Requested Records**

**Purpose for the Request or Rlease**

* **Referral Care (I would like to send these to my PCP to aid in my care)**
* **Insurance (At this time Between Two Points Acupuncture LLC does not take insurance, however if you would like this for your records)**
* **Legal**
* **Disability**
* **Personal**
* **Other**

|  |  |
| --- | --- |
| **REQUEST FROM** | **RELEASE TO** |
| **NAME** | **NAME** |
| **ADDRESS** | **ADDRESS** |
| **PHONE** | **PHONE** |
| **CITY** | **CITY** |
| **STATE** | **STATE** |
| **ZIP** | **ZIP** |
| **FAX** | **FAX** |

**DISCLOSURE STATEMENTS**

* **I understand that this authorization will be in effect for 12 months unless cancelled by me in writing. The cancellation will take effect when the provider receives my notice in writing. I understand that once information is discloed by a provider that the disclosed information may no longer be protected by privacy law.**

**AUTHORZIATION**

* **I authorize the above provider to release the information marked above to the requestor.**

**Print name:**

**Signature:**

**Date:**