Authorization for Release of Information

I, _____, hereby authorize Rachel Weiss, MS, L.Ac. to disclose the following protected health information to _____ at location _____: dates of service, types of services provided and all medical information except for specially protected medical information as obtained during consultation and service.

This protected health information is being used or disclosed to carry out treatment, payment and/or health care operations of Rachel Weiss, MS, L.Ac. in the following manner: to understand and support the recommendations and treatment strategies of _____.

This authorization shall be in force and effect until _____, 20___, at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Rachel Weiss, MS, L.Ac. or at rachel.acupuncture@gmail.com.

I understand that a revocation is not effective to the extent that either Rachel Weiss, MS, L.Ac. or _____ has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Rachel Weiss, MS, L.Ac. will not condition my treatment, payment, enrollment (if applicable) in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to refuse to sign this authorization.

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative (PRINT)

_____

Description of Personal Representative's Authority