MICHELLE MANTO

Berkshire Acupuncture & Wellness

Helping People Heal

AUTHORIZATION FOR RELEASE OF INFORMATION

Name: _____ DOB: _____ I hereby authorize Michelle Manto and Berkshire Acupuncture & Wellness to release my health information to:

1. The following person(s) regarding my general medical condition, diagnosis, treatment, payment and health care information:

   Name and Phone #: _____

   Name and Phone #: _____

2. The following person(s) ONLY IN AN EMERGENCY:

   Name and Phone #: _____

   Name and Phone #: _____

3. The following providers for concurrent care:

   Name of healthcare provider: _____

   Address/Phone #: _____

   Name of healthcare provider: _____

   Address/Phone #: _____

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the information to be disclosed. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that I have the right to refuse to sign this authorization and that my treatment is not conditioned on my signature. I understand this authorization shall be in effect until revoked by me.

_____ _____

Patient Signature Date

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