HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

COMPLETE THIS FORM IF: You want a family member or friend to be able to make or change appointments for you, accompany you into the treatment room, speak with your providers about your progress, treatment, etc. A new form must be filled out for each designee.

Patient: ________________________ Date of Birth: ___________ SSN:__________________

EAST LAKE ACUPUNCTURE may disclose this health information to the following recipient:

Name: ____________________________ **Phone**: _________________________

Relationship:

The purpose of this authorization is (check all that apply): I authorize my provider(s) at **East Lake Acupuncture** to discuss my treatment with the above-designated individual to communicate with my provider(s) regarding the following:

☐ **Make/change appointments ONLY.** May not discuss my case or healthcare. Limited to making, cancelling or changing appointments ONLY.

☐ Discuss **any and all** of my care, progress, treatments, appointments, payment and/or billing matters and all health information **without restrictions**, with the exception of certain conditions, which require additional consent (see below), covering the period from ______ to _______ , or ☐ **For all periods of time, past present, or future unless revoked in writing.**

☐ Discuss my health information relating ONLY to the following treatment or condition(s):________________________ **Signature of Patient ____________________________ Date:______________**

Parent/Guardian ____________________________ **Signature of Parent/Guardian**: _______________________ Date:______

ADDITIONAL CONSENT FOR CERTAIN CONDITIONS

This medical record may contain information including mention in chart notes about physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment. Separate consent must be given for each of the conditions listed below, before this information can be released. If you do not itiial and sign, it will be assumed that you do NOT authorize the person listed above, to have the information.

____ (initials) I consent to have the above information released to the person listed above

Additional Consent for HIV/AIDS: This medical record may contain information concerning **HIV testing and/or AIDS diagnosis or treatment**. Separate consent must be given to have this information released.

____ (initials) I consent to have the above information released to the person listed above

Additional Consent for Certain Conditions: This medical record may contain information including mention in chart notes about **physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment**. Separate consent must be given before this information can be released.

____ (initials) **I consent** to have the above information released to the person listed above

This additional consent/authorization ends: ☐ On (date)________________ ☐ When revoked in writing

Signature of Patient ____________________________ Date:______________

Parent/Guardian ____________________________ **Signature of Parent/Guardian**: _______________________ Date:______

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards. **YOUR RIGHTS:** You the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon your original permission. You may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, you must do so in writing and send it to the appropriate disclosing party. Please be aware that it is possible that information disclosed with your permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards. The purpose of this document is to inform us of anyone whom you wish to allow to make or change your appointments, discuss your care, progress, or case with your provider(s), and/or to share or otherwise disclose your records in whole or in part, to another person or entity. You have the right to refuse to sign this authorization. This document is not a consent to treat. Treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study. If you are uncertain about the purpose of this document, please ask for clarification. You have the right to a copy this authorization after you have signed it. A copy of this authorization is as valid as the original.