



**MEDICAL MASSAGE  
ACUPUNCTURE**

**Authorization to Use or Disclose My Health Care Information**

Patient name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Previous name: \_\_\_\_\_

**I. My Authorization for \_\_\_\_\_ to disclose health care information.**

**You may use or disclose the following health care information (check all that apply):**

- All health care information in my medical record
- Health care information in my medical record relating to the following treatment or condition:  
\_\_\_\_\_
- Health care information in my medical record for the date(s): \_\_\_\_\_
- Other (e.g., X rays, bills), specify date(s): \_\_\_\_\_

**You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):**

- HIV (AIDS virus)  Psychiatric disorders/mental health
- Sexually transmitted diseases  Drug and/or alcohol use

**You may disclose this health care information to:**

Name (or title) and organization: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone\*\* \_\_\_\_\_ FAX\*\* \_\_\_\_\_ (\*\*  
required information)

**Reason(s) for this authorization (check all that apply):**

- at my request  other (specify) \_\_\_\_\_

**This authorization ends:** *(This document does not permit disclosure of health information created more than 90 days after the date it is signed.)*

- in 90 days from the date signed  on (date): \_\_\_\_\_
- when the following event occurs: \_\_\_\_\_  
(no longer than 90 days from date signed)

**II. My Rights**

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study or
- To receive health care when the purpose is to create health care information for a third party. I may revoke this authorization in writing. If I did, it would not affect any actions already taken by [name of practice or health care facility] based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are: • Fill out a revocation form. A form is available from the [practice/health care facility]. Or
- Write a letter to the [practice/health care facility].

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

\_\_\_\_\_  
Patient or legally authorized individual signature \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

\_\_\_\_\_  
Printed name if signed on behalf of the patient \_\_\_\_\_ Relationship  
(Parent, legal guardian, personal representative)

Last Update: \_\_\_/\_\_\_/\_\_\_

