North Scottsdale Acupuncture
10250 N. 92nd Street, Suite 301, Scottsdale, AZ 85258

Authorization to Release Health Information

HIPAA privacy regulations stipulate that health care providers may not use or disclose a patient's health information without his or her authorization, except as described in the Notice of Privacy Practices. That document clarifies the conditions under which a patient's information may be released without his or her authorization, and when an express authorization is required by the patient.

Under certain circumstances, it may become necessary for this office to release a patient's health information to an individual or entity outside of this office. In accordance with the Notice of Privacy Practices, this office, via this authorization form, requests that the patient indicated below authorize the release of his/her health information.

I, the undersigned, understand that I have the right to:

- Refuse to sign this authorization
- Receive a copy of this authorization
- Restrict what is disclosed by this authorization
- Inspect or request an amendment of the health information to be disclosed
- Revoke this authorization, by written notice
- Know about any compensation the practitioner/facility will receive resulting from the release of my health information

I understand that whether or not I sign this document will not effect my treatment at this prace, the payments I incur here, or my eligibility for benefits of any sort. If I do experience any such negative repercussions, I have the right to file a complaint with the Office of Civil Rights of the U.S. Department of Health and Human Services. I can find the Office for Civil Rights for my state at: http://www.hhs.gov/ocr/regmail.html.

Patient Name: _____

Address: _____

Date of Birth: _____

Health information to be disclosed: _____

Individual(s), entities or business associates to receive this health information: _____

Specific purpose of this disclosure: _____

Effective dates of this authorization: ____/____/____ through ____/____/____
(The authorization will expire at the end of this period.)

I hereby authorize this office to disclose my health information as described in this document.

_____ _____
Signature of Patient (or Authorized Representative Date

_____ _____
Signature of Practitioner or Facility Representative Date