ACUPUNCTURE
WELLNESS CENTER LLC
EAT WELL - LIVE WELL - BE WELL

3712 MacArthur Blvd. Ste 208. New Orleans, LA 70114
Tel. 504-362-8020
info@nolaacupuncture.com
www.nolaacupuncture.com

Authorization to Disclose Health Information

Client Identification:

Client Name:_____ Date of Birth:_____ Client SS # (optional):_____
Client Address:_____
Street Apt # City State Zip
Home Phone:(_____)_____ Work Phone : (_____)_____ Cell Phone : (_____)_____

Authorization

I _____ hereby authorize_____
Name of Client or Personal Representative *Name of Provider/Plan*
to disclose specific health information from the records of the above named client
to:_____
Recipient Name/Address/Phone/Fax
_____
for the specific purpose(s): from_____
_____
specific information to be disclosed: _____
_____

I understand that this authorization will expire on the following date, event or condition: _____
_____

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the *Revocation Section* on the back of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

I further understand that I may request a copy of this signed authorization.

_____ _____ _____
Signature of Client Date Witness – If Required

_____ _____ _____
Signature of Personal Representative Date Personal Representative Relationship/Authority

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NOTE: This Authorization was revoked on _____ _____
Date Signature of Staff

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Revocation Section

I do hereby request that this authorization to disclose health information of _____ signed
Name of Client
by _____ on _____ be rescinded, effective _____.
Name of Person Who Signed Authorization *Date of Signature* *Date*

I understand that any action taken on this authorization prior to the rescinded date is legal and binding.

Signature of Client	Date	Signature of Witness	Date
Signature of Personal Representative	Date	Personal Representative Relationship/Authority	

Verbal Revocation Section

I do hereby attest to the verbal request for revocation of this authorization by _____ on
Name of Client or Personal Representative
_____. The client or his/her personal representative has been informed that any action taken on this authorization
Date
prior to the rescinded date is legal and binding.

Signature of Staff	Date	Signature of Witness	Date