CAMDEN ACUPUNCTURE

Amy Jenner — *M.Ac., Dipl.Ac., L.Ac.*

I, _____(Name), _____(Date of birth)

Authorize Amy Jenner, L.Ac to consult with the following practitioner(s) regarding my protected health information.

Please list practitioner(s) _____

I specifically authorize that any sensitive information regarding (Check all that apply)

___HIV/AIDS ___Substance abuse (alcohol or drugs) or ___Mental Health

be released to the above recipient.

I understand that if the authorized recipient is not a provider, health plan, or clearinghouse required to comply with federal privacy standards, the information disclosed pursuant to this authorization may no longer be protected by federal privacy standards and my health information may be re-disclosed by the recipient without obtaining any further authorization.

INDIVIDUAL'S RIGHTS RELATING TO THIS AUTHORIZATION:
I understand that I must be provided with a copy of this form if I choose to sign it. I understand that I am under no obligation to sign this form and that the practice may not condition my treatment, payment, or enrolment/eligibility for benefits in my decision to sign this form. I understand that I may revoke my Authorization or to receive a copy of my revocation, I am to contact Camden Acupuncture. I am aware that my revocation will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) listed above have already made in reliance on this Authorization.

EXPIRATION DATE: This authorization is valid until_____.

I have had an opportunity to review and understand the content of this Authorization form. By signing this Authorization, I am confirming that it accurately reflects my wishes.

_____ _____
Patient's signature Representative (if applicable)

_____ _____
Date: Rep's relationship to patient

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