AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I,
(Patient’s name)

D.O.B. LAST FOUR OF SS#

GIVE:

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION REGARDING

(Name)

(Address)

THE FOLLOWING TYPES OF INFORMATION ARE SPECIALLY AUTHORIZED

EXPIRATION DATE OF THIS AUTHORIZATION: / /

____
(Patient’s signature) (Date)

____
(Witness signature)

Our Notice of Privacy Practices provides information about

Acupuncture and Asian BodyWork