

ACUPUNCTURE AND CHINESE MEDICINE CENTER

7250 France Avenue South, Suite 308, Edina MN 55435 • Phone: (952) 820-0877 Fax: (952) 820-3080

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ Telephone: _____

Information to be Released From:

Doctor/Clinic Name: _____

Address: _____

Phone Number: _____

Information to be Released To:

Eileen Zhuo, L.Ac. / Nicole Cullinan, L.Ac.

Acupuncture and Chinese Medicine Center

7250 France Ave So Suite 308

Edina, MN 55435

Phone Number: 952-820-0877 Fax: 952-820-3080

Information to be Disclosed:

Entire Medical Record

Progress Notes

IVF Stimulation Summary Sheet

Lab Reports (including Semen Analysis)

For the following date(s) of treatment: _____

Other (Specify): _____

Information to be Released By:

Fax: **952-820-3080**

Mail

Phone

All records pertaining to psychiatric/mental health, chemical dependency, and/or HIV/AIDS related illness/testing will be released unless otherwise indicated by a checkmark here: _____

Please indicate any restrictions. (Specify) _____

The information is being requested for the following purpose:

Continued Care Insurance Legal Personal Use Other: _____

- I understand I may revoke this authorization by written request at any time to the address listed at the top of this form. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- I understand that this authorization will automatically expire one year from the date of my signature.
- I understand that once information is released pursuant to this authorization, it may be subject to re-disclosure by the recipient to another third party.
- I understand there may be a charge associated with the Release of Information Services rendered. There is no charge for release of information to other health care facilities.

Signature of Patient/Legal Guardian

Date

Relationship if not Patient