ASIAN HEALING ARTS

acupuncture | herbal therapies | massage

Authorization Form for Patient Medical Records Release (Please Print)

Patient Name: _____
(Last, First, Middle)

Date of Birth:_____

Person/organizations authorized to use or disclose my information:
Asian Healing Arts Acupuncture
36889 North Tom Darlington Drive, Suite D6-8
Carefree, AZ 85377

Person/Organization who may receive my information:

Specific description of the information to be used or disclosed (Including dates):

The patient or patient's representative must read and initial the following statements:

1. I understand that I may refuse to sign this form and that my health care and the payment for my health care will not be affected if I do not sign. **Initials** _____
2. I understand that I will get a copy of this form after I sign it. **Initials** _____
3. I understand that I may revoke this authorization at any time by notifying the Practice in writing, but if I do, the revocation will not have any effect on action already taken on this authorization.
   Initials _____

_____ _____

Signature of Patient/Representative **Date**

If this authorization is signed by a patient's representative, please complete the following:
Printed name of patient's representative:
Relationship of representative to the patient:
Describe the representative's authority to act for this patient:

**You may refuse to sign this authorization*