Authorization of Release Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can & will be used to:

- Conduct, plan & direct my treatment & follow-up among healthcare providers who may be involved in the treatment directly & indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessment & physician certifications.

I ____hereby give my consent to Shelly R. Greene, LAc. To release information regarding my healthcare to the following person(s):

My Spouse:_________________________________Phone#__________________Initials______

Parent(s):________________________________Phone#__________________Initials______

Other(s):_________________________________Phone#__________________Initials______

I understand I may revoke this permission in writing at any time.

Patient Signature:____Date______________

I do not wish to share my information with anyone.

Patient Signature:____Date______________

Shelly Greene, LAc.

Peaceful Points Acupuncture

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