Boulder Body Balance Acupuncture Clinic

3004 Folsom Street * Boulder, Colorado, 80304* Tel- (720)-509-9588

Patient Disclosure Authorization Form

Patient Name:_____ Date of Birth:_____

I authorized disclosure of my protected health information only in the specific matter, for the named reason, and to the specific Individual(s) described below.

Specific description of information to be used or disclosed:_____

Reason for request use or disclosure: ☐Patient request (personal reasons)
☐Employment related or to substantiate a disabilities
☐ Other_____
Office staff at this practice authorized to disclose my information:_____

Person or entity (ies) to who this practice will give my information

Name:_____Address:_____

This authorization will expire on the following.
☐Date: _____
☐Event (relating to patient or the purpose of the disclosure): _____

This authorization provides that:

- I may revoke this authorization at any time, provided that the revocation is in writing to the Privacy Officer at this practice, except if this practice has taken action relying on this consent or if the authorization was obtained as a condition of obtaining insurance coverage.
- Information used or disclosed pursuant to this authorization may be subject to redisclose by the recipient and no longer be protected by HIPAA privacy rules.
- This practice will not condition treatment on my providing authorization for the requested use or disclosure.
- I have the right to access my protected health information to be used or disclosed.
- I will receive a copy of this complete and signed authorization form.

_____

Patient's or Guardian's Name Printed Date

_____

Patient's or Guardian's Signature Date