Tracy Andrews
ACUPUNCTURE

# AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Name : _____ DOB: _____
(Individual whose information is to be disclosed)

I authorize Tracy Andrews, LAc to
_____ exchange information with
_____ release information to the following individual(s) or agenc(ies):

_____
(Name of facility or provider) (Address)

_____ _____
(Phone) (Fax number)

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

_____ General health information including health status and treatment _____ Drug & Alcohol information

_____ Mental health information

Consisting of all health information unless otherwise specified here: _____

Purpose of disclosure: This information will be used for evaluation and to plan for and coordinate services for me, my family or for other purposes specified here: _____

This authorization becomes effective on the date below and will expire 1 year from termination of treatment with Tracy Andrews, LAc unless I indicate otherwise: ☐ Specific expiration date: _____

I understand that I do not have to sign this authorization. Refusal to sign this authorization will not adversely affect my ability to receive health care services or reimbursement of services. I have a right to refuse to sign this authorization. The only circumstance when refusal to sign means I will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

I also understand that when my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

I have the right to revoke authorization in writing except to the extent that Tracy Andrews, LAc has acted in reliance upon it. My written revocation must by received by Tracy Andrews, LAc.

_____ _____
Client Signature Date

☐ Client (14 and older) ☐ Guardian
☐ Parent ☐ Legal Custodian _____
Parent or Guardian Signature (if applicable) Date

Redisclosure: Information received under this authorization should not be redisclosed to any party not identified on this form without specific written consent. Criminal penalties may apply to illegal disclosure. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosures of Alcohol/Drug Information without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

200 NE 20th Avenue, Suite 120 • Portland, OR 97232
tracy@tracyandrewsacupuncture.com
Ph. 971-251-0320 • F. 503-893-3103