Permission to Maintain and Release Medical Records

Patient Name: _____

Date of Birth: _____ Social Security #: _____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

> *Permission is herby granted for release of medical information: I release Cindy Campbell/Acupuncture Wellness Center from all legal responsibility of liability that may arise from this authorization.*

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

_____

I do_____ I do not_____ specifically consent to transmission of my medical records via a facsimile (fax) machine or EDI transmission

_____ _____

Signature of patient or representative | Relationship of representative if minor

_____ _____

Date Signed | Witness