Consent to Release Health Information

I, _____(client name - printed), hereby authorize Holly Leever, L.Ac. (see list below) and the following party:

Name: _____ Relation to Client: _____

Address: _____

E-Mail: _____

Phone: _____Fax: _____ and their respective agents, and/or employees, to disclose to and/or obtain from each other any and all information and/or records regarding my diagnosis and treatment and other pertinent information relative to my past, present, or future condition. I realize that the exchange and disclosure of information between each of such parties is for the purpose of assisting all involved in properly treating me and facilitating transition of care. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I may also request that only specific information is communicated. Furthermore, I understand that I may revoke this authorization at any time. If I revoke this authorization, I must do so in writing to the applicable parties named herein. I understand that the revocation will not apply to information that has already been released in response to this authorization. Additionally, I understand that treatment or payment cannot be conditioned on my signing this authorization. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal or state confidentiality rules.

This authorization expires automatically two (2) years from the date signed. I have received a copy of the signed authorization.

Patient Name (Printed):_____

Patient Signature:_____ Date:_____