



INDIVIDUAL RIGHTS RELATING TO THIS AUTHORIZATION

I understand that I must be provided with a copy of this form if I choose to sign it.

I understand that I am not required to sign this form.

I understand that my treatment, payment, or eligibility of benefits will not be affected by my decision to sign this form.

I understand that I may see and have a copy of the information described on this form, if I ask for it and I will receive a copy of this form after I sign it.

I understand that I may revoke this authorization at any time by notifying the Intern Clinic in writing, and if I do, it won't have any effect on any actions in this office.

I understand that this authorization is valid until _____ .

I have read this form and understand the Authorization for Release of Health Information form.

Patient or Representative

Date

Eastern School of Acupuncture Staff Member

Date