AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I, ____,
hereby authorize the staff of the Eastern School of Acupuncture Intern Clinic, to use or disclose my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

Persons/Organizations receiving this information:
____
____
____

I request that the health information, to be released, consist of the following: (mark the ones you want released)

- □ **Complete Acupuncture Records (Intake Form and Progress Notes)**
- □ **Acupuncture Progress Notes Only from (Date) ________ to (Date) _______.**
- □ **Medical Diagnosis or Referral Records**
- □ **Laboratory or Medical Test Results**
- □ **Supervisor Summary or Report (if specifically requested)**
- □ **Herbal Data**
- □ **HIV/AIDS (sensitive information)**
- □ **Substance Abuse (drug or alcohol abuse)**
- □ **Mental Health Information**
- □ **Other____**

______________________________________ ____________________
Patient or Representative (relationship to patient) **Date**

______________________________________ ____________________
Eastern School of Acupuncture Staff Member **Date**

427 Bloomfield Ave. Suite 306 ● Montclair, NJ 07042
Phone: 973-746-2848 ● Fax: 973-746-2088