JEAN-CHRISTOPHE PRIN
ACUPUNCTURE • CLASSICAL CHINESE MEDICINE

HIPAA - NOTICE OF PRIVACY PRACTICES

Authorization to disclose medical information:

No medical information with any third parties will be discussed, unless written consent / authorization has been obtained from you. (This includes by telephone, fax, letter, e-mail, or in person.) This consent form gives us permission to do so.

Ways in which this information might be used:

TREATMENT: Such as when our providers discuss your care or provide information to another health care provider for the continuation or supplementation of your care.

INSURANCE: If your insurance company requests copies of your records.

FAMILY: Such as sharing information with members of your family that you choose.

I authorize the following individuals(s) to receive my medical information:

_____, _____
Full name — Relationship to patient

_____, _____
Full name — Relationship to patient

_____, _____
Full name — Relationship to patient

_____, _____
Full name — Relationship to patient

You may request a copy of your this authorization. You may revoke authorization at any time in writing. You may refuse to sign this authorization. You have the right to request access to your protected health information that may be used or disclosed.

Patient name (Please Print): _____

Signature of Patient (or legal guardian):

_____ Date: _____

Signature of Covered Dependent if 18 or over:

_____ Date: _____

If you do not want your records disclosed to anyone, draw a line through the above authorization section and sign below so as to acknowledge having seen this form.

_____ _____ _____
Print Name *Signature* *Date*