EnPointe Acupuncture

Vestal Chiropractic Center

1136 Front Street, Vestal, N.Y. 13850

(607) 748-5145

PATIENT AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name ______________________________ **Medical Record # (if known)** ____________

Date of Birth ______________________ **Phone #** ______________________________

Address ____

1. I authorize Daniel R. Fluegel, DC and Mary Lee, MSA, LAc **TO DISCLOSE** my health information in paragraph 2 to each other.

2. a. Please disclose this health information about me:
   - ☐ my complete health record (including records relating to mental healthcare, communicable disease, HIV, and treatment of alcohol or drug abuse).

   ** OR **

   - ☐ my complete health record with the exception of the following information:
     - ☐ Mental health records
     - ☐ Communicable disease including HIV and AIDS
     - ☐ Alcohol/drug abuse treatment
     - ☐ Other – please specify: ______________________________________

   b. During these dates (that I was seen or treated):
   ☐ from ______________ to ______________ ** OR ☐ all past, present and future dates.

3. This medical information is to be used by Daniel R. Fluegel, DC and Mary Lee, MSA, LAc for healthcare treatment or consultation, billing or claims payment or other purposes as I may direct.

4. I may decide not to sign this authorization. Daniel R. Fluegel, DC and Mary Lee, MSA, LAc will NOT deny me treatment solely for that reason.

5. If I do sign this authorization, I may revoke it at any time, except as to records already disclosed. To revoke this authorization, I need to send a revocation in writing to Daniel R. Fluegel, DC and /or Mary Lee, MSA, LAc.

6. If I was referred to or participated in a substance abuse treatment program on the dates I was seen or treated, I understand that this authorization may disclose information about my participation in that program.

7. This authorization shall be in effect as long as I am receiving treatment from Daniel R. Fluegel, DC and/or Mary Lee, MSA, LAc., unless I revoke it or put another expiration date here: ________________

8. I may request a copy of my health information from Daniel R. Fluegel, DC and/or Mary Lee, MSA, LAc.

______________________________ ______________________________ ________________

Signature of Patient or Representative | Patient's Name | Date

(if applicable) ______________________________ ______________________________

Name of Personal Representative | Relationship to Patient