Balanced Living Acupuncture

Blanca O. Lopez, M.D.

HIPAA Disclosure Authorization

I, _____, direct Balanced Living Acupuncture, LLC, to disclose and release my protected health information described below to (Note: Any information disclosed to a party not covered by HIPAA may no longer be protected from further disclosure by that party):

Name	Relationship	Phone Number

Health Information to be disclosed upon the request of the person named above — (Check either A or B):

- ☐ A. **Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) **OR**

- ☐ B. **Disclose** my health record, as above, **BUT do not disclose** the following (check as appropriate):
  - ☐ Mental health records
  - ☐ Communicable diseases (including HIV and AIDS)
  - ☐ Alcohol/drug abuse treatment
  - ☐ Other (please specify):

_____

_____

_____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

- ☐ An electronic record or access through an online portal
- ☐ Hard copy

This authorization shall be effective until (Check one):

- ☐ All past, present, and future periods, OR
- ☐ Date or event: _____

unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying Balanced Living Acupuncture, LLC, preferably in writing. This will not impact the release of any information released prior to revocation.)

_____ _____ _____

Patient Name (Print) Patient or Guardian Signature Date

Relationship to Patient if Other than Patient: _____

Note: Treatment will not be impacted in any way, whether or not this form is or is not completed and/or signed.
HIPAA Authority for Right of Access: 45 C.F.R. § 164.524