Harmony Acupuncture, LLC
Virginia Beach, VA

Disclosure Request Form

I understand that my health information is private and that use of my health information must be consistent with the Institute's Notice of Privacy Practices. I further understand that certain disclosures of my health information may only be provided by my written consent. I therefore make the following request, and understand I may revoke this consent at any time except to the extent that action has been taken in reliance on it.

I, _____ D.O.B. _____ ,
(Printed Name of Client/Patient) (Date of Birth)

Was a client at the Harmony Acupuncture, LLC clinic, of practitioner

_____, last seen on _____ ,
(Name of Practitioner) (Date of Last Treatment)

request or authorize Harmony Acupuncture, LLC to disclose to: _____
(Name of Person or Agent)

_____
(Address)

the following information: _____
(Nature of Disclosure)

_____

for the purpose of □ move to new practitioner, □OTHER- list below

_____

This consent expires automatically upon the following date, event or condition:

_____

Client/Patient Signature: _____ Date _____

For Office Use Only:

□Disclosure implemented

□Disclosure denied – Reason for Denial _____

_____

Administrator Signature _____ Date _____

Verson 1.1: 1/8/2017