AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I, ____, hereby

authorize, Chia Chia Cheng L.Ac,, Traditions Acupuncture, the use or disclosure of 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 the information:

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

- ❑ Complete Acupuncture records
- ❑ Treatment or Tests
- ❑ Allergy Records
- ❑ Medical History or Evaluation Records
- ❑ Herbal Data
- ❑ Consultation Report
- ❑ HIV/AIDS (sensitive information)
- ❑ Substance Abuse (drug or alcohol abuse)
- ❑ Mental Health Information

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Patient Signature   Date