Authorization of Health Record Information Disclosure
Center for Complementary Medicine Inc.
Lyn Swirda Lic.Ac., M.Ac., Dipl.Ac.

I hereby authorize **Lyn Swirda, Licensed Acupuncturist**, to release my health record information for the purpose of collaborative care to the listed practitioner below:

Name _____

Address _____ City_____

State_____ Zip code_____ Telephone_____

I consent that you may use the following modes of communication:

☐ verbally communicate with listed practitioner

☐ release copies of my written treatment records

This authorization covers the following records:

☐ All Records

☐ Records for Acupuncture treatment of _____

(please specify diagnosis or specific symptoms)

☐ Records for treatment received during the following time period:

Dates: _____ to _____.

This authorization for disclosure (unless expressly revoked earlier, by written request) expires 3 months from which the patient or authorized agent of the patient signed. I am not giving permission for re-disclosure of this information. The person or organization receiving this information is expressly prohibited from leasing this information to another party without the written consent of the patient or his/her authorized agent. _____ (initials)

I hereby acknowledge that I have read, or have had read to me, and fully understand the above statements as they apply to me and do voluntarily consent to disclosure. _____ (initials)

Signature_____ Date_____