ACUPUNCTURE AND INTEGRATIVE MEDICINE ASSOCIATES OF NASHUA
AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Patient Name: ____ Date of birth: ____________________
Address: ____
I authorize *Dr. Lucinda M. Fecteau, PhD, OT/L, LAc and/or Acupuncture and Integrative Medicine Associates of Nashua PLLC* to release my protected health information (PHI) described below to:

Name: _______________________________
Address: _____________________________
____
____
Phone/Fax: ___________________________

Name: ____________________________________
Address:____________________________________
____
____
Phone/Fax: ________________________________

Purpose: __Consultation __Changing provider __Changed insurance __ Patient Request __ Other: __________
____

Specific PHI to be released: __Complete medical records __Dates of service requested/other: ________________
____

Under federal guidelines, information about diagnosis and treatment of alcohol and/or drug abuse, psychiatric treatment, testing for HIV, diagnosis of, treatment for and/or identity as an AIDS or ARC patient may not be released without specific authorization. Special authorization for release of information about treatment of anxiety and depression is not required. I authorize release of information concerning:

Initials: _____Psychiatric treatment
Initials: _____HIV testing and results
Initials: _____ Diagnosis of/ treatment for or reference to my identity as an AIDS or ARC patient
Initials: _____Drug and/or alcohol abuse and treatment

I have read and understand this authorization form. I understand that I may inspect or copy the protected health information described in this authorization. I understand that this authorization may be revoked in writing and delivered to Acupuncture and Integrative Medicine Associates of Nashua PLLC at any time, except to the extent that action has already been taken in reliance on this authorization. I understand that there is the potential for re-disclosure by the recipient of the information. I understand that Dr. Lucinda M. Fecteau, PhD, OT/L, LAc and/or Acupuncture and Integrative Medicine Associates of Nashua PLLC shall not condition treatment, payment, enrollment in a health plan or eligibility for benefits on my providing authorization for the requested use or disclosure and that I may refuse to sign this authorization. I understand that a fee may be charged for copies of records which are not sent directly to another medical provider. I release Dr. Lucinda M. Fecteau, PhD, OT/L, LAc, Acupuncture and Integrative Medicine Associates of Nashua PLLC and all employees and affiliates from legal responsibilities that may arise from the release of these records.

This authorization will expire on _________/________/___________.
If no date or event is specified, the authorization shall expire six months from the date it is signed.

________________________________ ________________________________ _______________
Patient or Representative Signature Patient or Guardian Printed Name Initials

______________________________________ ________/________/_____________
Relationship to Patient (self, parent, guardian, etc) Date