PERSONAL BALANCE ACUPUNCTURE SERVICES

MEDICAL DISCLOSURE REQUEST FORM

I understand that my health information is private and that use of my health information must be consistent with Personal Balance's 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, ______________________________, DOB: _____________________, am/was a client at Personal Balance Acupuncture and Reiki Services with practitioner, Sharon E. Miller, M.Ac. I hereby request or authorize ______________________________________ to disclose my health information as stated below:

____ my health record from ___________________ to ________________.

____ my entire health record, including client/patient histories, office notes, test results, consults, billing records, insurance records, and records provided by other health care providers.

____ Other: ____

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This consent automatically expires on ______________________________.

____ _________________________

Signature of Client/Patient Date