Becky Andrews ND, LAc
Si Shou Acupuncture Wellness
5424 W US Higway 290, Suite 106, Austin, TX 78735
Phone / Fax: (512) 3874002

Authorization to Release Confidential Health Information

I Hereby Authorize:

- ☐ Becky Andrews ND, LAc
- ☐ Si Shou Acupuncture Wellness
- ☐ Other: ____

To Release:

- ☐ Complete Chart Record *(does not include billing information or radiographic images)*
- ☐ Chart Notes ☐ All ☐ Specify: ____
- ☐ Labs / Reports ☐ All ☐ Specify: ____
- ☐ Billing Records ☐ All ☐ Specify: ____
- ☐ X-rays / Radiographic images (Specifiy): ____
- ☐ Other: ____

From the Health Records of:

Patient Name: ____________________________________ Date of Birth: ___________________
Daytime Phone: _________________ ext:____
Are you authorizing the release of your own records? ☐ Yes ☐ No
If not, what is your relationship to the patient? ____

To Be Released to:

- ☐ Self (please provide current address) ** fee may apply**
- ☐ Becky Andrews ND, LAc
  5424 W. US Highway 290, Suite 106, Austin, TX 78735
  Phone/ fax: 512-387-4002

- ☐ Facility / Doctor's Name:____
  Address:____
  City:___________________________ State: _______ Zip: ____________________
  Phone: _________________________ Fax: _________________________________

For the Purpose of:

- ☐ Adjunctive / Concurrent Care
- ☐ Continuation of Care
- ☐ Transfer of Care
- ☐
- ☐ Legal
- ☐ Insurance
- ☐ Patient Request
- ☐ Other___________________

I understand that in order to revoke this authorization, I must do so in writing. I understand that my health care information is protected by state and federal regulations. I understand that my healthcare information may not be released or disclosed without my written authorization, unless otherwise provided for by law. I also understand that if I authorize a third party that is not required to comply with such regulations to receive my health care information, my information may be re-disclosed by that party and would no longer be protected. I understand that I do not have to sign this form to receive care, and that I am entitled to a copy of this form at the time of signing. I may call the clinic to inquire about revoking authorization. I understand that if I request records for personal use, to hand carry to another provider, or for parties not involved in my health care, there may be a charge. There is no charge to release records to another healthcare provider. This authorization expires in ______ days (90 days if not otherwise specified). Minors signature required for certain conditions.

______________________________ ____________ ________________________

Patient Signature Date Relationship to Patient