

South Riding Acupuncture, LLC

4229 Lafayette Center Drive

Suite 1900

Chantilly, VA 20151

(703)209-3106

HEALTH CARE AUTHORIZATION FORM

Patient's Name _____

Date _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES **SOUTH RIDING ACUPUNCTURE** TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

Yes/ No I give permission to **South Riding Acupuncture** to use my address, phone number and clinical records to contact me with birthday cards, related reminder cards, and information about treatment alternatives or other health related information.

By signing this form you are giving **South Riding Acupuncture** permission to use and disclose your protected health information in accordance with the directives listed above.

Print Name

Signature (or parent if a minor)

Date