AUTHORIZATION TO RELEASE OR DISCLOSE PROTECTED HEALTH INFORMATION

Parents' Name(s): _____

Patient' Name: _____

Current Mailing Address:

_____

_____

_____

I hereby authorize the **Inova-SPH Institute for Traditional Chinese Medicine, LLC** to provide protected health information and/or financial information about me to

_____

for the purpose of

_____.

I understand that if the person or agency that receives my information is not a health care provider or health plan covered by the HIPAA privacy regulations, the information described above may be redisclosed and is no longer protected by these regulations.

I understand that written notification is necessary to cancel this authorization and can be addressed to the Institute at 3833 North Fairfax Drive, Suite 110, Arlington, VA 22203. I am aware that my cancellation will not be effective as to disclosures already made in reference to this authorization.

I understand I am under no obligation to sign this authorization in order to receive services at the Institute.

_____

Print Name

_____

If Personal Representative of the Patient, please list relationship

_____

Signature

_____

Date

This authorization shall remain valid for one (1) year from the date it is signed, unless revoked.