Dr. Christina Fick, L.Ac, DAOM, MSTCM, MSAc, Dipl.Ac.
DrChristinaFick@gmail.com
28265 Hwy 74, Evergreen, CO 80439
P: 303-594-8348 F: 303-484-5297

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R.Parts 160 and 164)

1) I agree to authorize Christina Fick, L.Ac. to □use□ and □disclose all □my□ protected□ health □information □to and from my Physician or listed healthcare providers (listed on my demographics/insurance form).

2) I authorize the release of my complete health record with the exception of:

☐ Mental Health Record ☐ Communicable diseases (including HIV/AIDs)

☐ Alcohol/drug abuse treatment ☐ Other _____

3) This □medical □information □may □be □used □by □the □person □I □authorize □to □receive□ this □information □for□ medical □treatment □or □consultation, □billing □or □claims□ payment, □or□ other □purposes □as □I □may □direct.□

4) This authorization shall be in force from the date listed at the bottom of this form until six months after the last Acupuncture treatment ceases with Christina Fick, L.Ac.

5) I understand I have a right to revoke this authorization, in writing, at any time. I□ understand □that □a □revocation □is□ not □effective □to□ the□ extent □that □any□ person□ or□ entity □has□ already□ acted □in□ reliance □on □my□ authorization □or□ if□ my□ authorization □was□ obtained□ as □a □condition □of□ obtaining□ insurance□ coverage□ and□ the□ insurer □has □a □legal □right □to □contest □a□ claim.□

6) □I□ understand□ that□ my □treatment,□ payment,□ enrollment,□ or□ eligibility □for□ benefits □will□ not□ be□ conditioned□ on□ whether □I□ sign □this□ authorization.□

7) □I□ understand □that□ information□ used □or□ disclosed □pursuant□ to □this□ authorization □may □be□ disclosed □by□ the □recipient□ and□ may □no □longer □be □protected□ by□ federal□ or□ state □law.

Signature of Patient or Guardian _____

Printed name of Patient or Guardian _____

Date _____