

ACUPUNCTURE HEALING ARTS CENTER  
733 East Main Street  
Torrington, CT 06790  
860.626.1167

Authorization form for disclosure/release of protected  
health information

Medical Provider: Dr. Allyson Sullivan Date: \_\_\_\_\_  
Address: 733 East Main Street, Torrington, CT 06790  
Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Patient Address: \_\_\_\_\_

1. I hereby authorize the medical provider stated above to release any information from my health records.
2. I understand that authorizing the disclosure of this health information is voluntary. I need not sign this authorization to ensure treatment, payment, or healthcare operations. I understand I may inspect or copy the information to be used or disclosed according to state and federal law and as stated in the Privacy Notice of this facility. I understand that information released from this facility may not be protected by federal confidentiality rules and carries with it the potential for an unauthorized re-disclosure.

A PHOTOSTAT COPY OF THIS AUTHORIZATION  
SHALL BE AS VALID AS THE ORIGINAL

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date