FINLEY
CENTER
acupuncture • naturopathic medicine
& physical therapy

Authorization to Disclose Protected Health Information.

I hereby authorized The Finley Center for Acupuncture, Naturopathic Medicine, & Physical Therapy to use and disclose my protected health information to:

_____	_____
Name	Relationship to Patient
_____	_____
Name	Relationship to Patient

Medical information may be used by the person I authorize to receive this information for medical treatment, consultation, billing or claims payment, and any other purposes as I may direct.

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

I understand that I have the right to revoke this authorization, in writing, at any time.

_____	_____
Patient Signature	Date