# Authorization for Release of Information

I, ___________________________, hereby authorize Stephen F. Cohen, MS, LAc d/b/a AXIOM Acupuncture or AXIOM Wellbeing to disclose the following protected health information to ________________________________ at location _______________________________________________: dates of service, types of services provided and all medical information except for specially protected medical information as obtained during consultation and service.

This protected health information is being used or disclosed to carry out treatment, payment and/or health care operations of Stephen F. Cohen, MS, LAc d/b/a AXIOM Acupuncture in the following manner: to understand and support the recommendations and treatment strategies of _________________________________.

This authorization shall be in force and effect until __________________, 20___, at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Stephen F. Cohen, MS, LAc d/b/a AXIOM Acupuncture at 49 West 24th Street, 8th Floor, New York, New York, 10010 or at stephen@axiomacupuncture.com. I understand that a revocation is not effective to the extent that either Stephen F. Cohen, MS, LAc d/b/a AXIOM Acupuncture or ________________________________ has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Stephen F. Cohen, MS, LAc d/b/a AXIOM Acupuncture will not condition my treatment, payment, enrollment (if applicable) in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to refuse to sign this authorization.

_________________________________________________ ________________

Signature of Patient or Personal Representative Date

_________________________________________________

Name of Patient or Personal Representative

_________________________________________________

Description of Personal Representative's Authority