AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I,_____, hereby authorize, Essential Wellness of Illinois, LLC and Christine A. Renz, L.Ac., the use or disclosure of my individually identifiable health information described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

Persons/Organizations receiving the information:

_____

_____

_____

I request that the health information, to be released, consist of the following (mark the ones you want to be released):

- ☐ Complete Acupuncture records
- ☐ Treatment or Tests
- ☐ Allergy Records
- ☐ Medical History or Evaluations Records
- ☐ Herbal Data
- ☐ HIV/AIDS (sensitive information)
- ☐ Substance Abuse (drug or alcohol abuse)
- ☐ Mental Health Information

_____

Patient Signature

_____

Date