**HIPAA Release of Health Information**

Date \_\_/\_\_/\_\_

Client’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_/\_\_/\_\_\_\_\_

 (M/DD/YY)

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize the release of information rendered

 (Name of Client)

 for the client, including the:

□ analysis

□ records & notes

□ recommendation

**-- To David M. Shein of Blackbird Homeopathy, LLC.**

I also authorize/release the Health Practitioner, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Of (City/State/Country), \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to discuss my case with

David M. Shein, of Blackbird Homeopathy, LLC, Rochester, NY. (585) 260-4965

(blackbirdhomeopath@gmail.com).

This Release of Information will remain in effect unless terminated by me in writing.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of Client Date