

**Dawn M. Matthews  
Acupuncture Physician**

*This authorization must be written, dated and signed by the patient or by a person authorized by law to give authorization. It is valid until revoked in writing. Records are requested for continuity of care. This clinic does not offer reimbursement for records received.*

Patient: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

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Please **obtain** information from the following:

Please **send** my medical information to:

\_\_\_\_\_  
Name of Physician

Dawn M. Matthews, AP

\_\_\_\_\_  
Name of Clinic/Hospital

\_\_\_\_\_  
Mailing Address

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
City, State, Zip Code

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*By **checking** the spaces below, I authorize the above physician/clinic to release written records pertaining to the following information going **back one year**. I also authorize the above physician/clinic to provide the following information via telephone consultation:*

\_\_\_\_\_ Medical records needed  
for continuity of care

\_\_\_\_\_ Diagnostic imaging reports  
\_\_\_\_\_ Laboratory reports

\_\_\_\_\_ Pathology reports

\_\_\_\_\_ Other:  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Signature of Parent/Guardian if Applicable

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*I understand that certain information in these records cannot be released without specific authorization because of federal or state laws. By **initialing** the spaces below, I specifically authorize the release of the following confidential information for me by Dawn M. Matthews, AP. I also authorize the above physician/clinic to provide the following information via telephone consultation:*

\_\_\_\_\_ HIV/AIDS test results and related information, including high-risk behavior documentation. This information may not be further disclosed without the specific written authorization of the tested individual.

\_\_\_\_\_ Drug/Alcohol diagnosis, treatment or referral information. Federal Regulation, 42 CFR Part 2, requires a description of how much and what kind of information is to be disclosed. Please provide a description of this information:  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ Mental health treatment information.

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**For Office Use Only:** Date Sent: \_\_\_\_\_ Initials: \_\_\_\_\_