Inner Peace Counseling and Wellness LLC

Release of Information: HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Date:

I. The Patient

This form is for use when such authorization is required and complies with the Health Insurance Portability Act of 1996 (HIPPA) Privacy Standards.

Client Full Name:

Client Date Of Birth:

Client ID Number:

SSN:

II. Authorization

I authorize [Agency/Provider Name]: to use or disclose the following: (check one)

- [ ] All of my medical-related information
- [ ] My medical information ONLY related to a specific diagnosis. (complete sentence below)

My medical information only related to:

- [ ] My medical-related information in a specified date range. (enter date range below)

Enter date range:

- [ ] Other (please explain below)

Please explain other:

III. Disclosure

The Authorized Party has my authorization to disclose Medical Records to: (check one)

- [ ] Any party that is approved by the Authorized Party.

☐ Only the following party (enter details below)

Name:

Address:

Phone Number:

Fax Number:

Email Address:

IV. Purpose

The reason for this authorization is: (check one)

☐ General Purpose at my request (general)

☐ To receive payment. To allow the authorized party to communicate with me for marketing purposes when they receive payment from a third party.

☐ Other (please explain below)

Explain other:

V. Termination

The authorization will terminate: (check one)

☐ Upon sending a written revocation to the Authorized Party

☐ On the following date: (enter below)

Date:

☐ Other (please explain below)

Explain Other:

VI. Additional Consent for Certain Conditions

Sensitive information. This medical record may contain information about physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment. Separate consent must be given before this information can be released.

Check One

☐ I consent to have the above information released.

☐ I do not consent to have the above information released.

VII. Acknowledgement of Rights

I understand that I have the right to revoke this authorization, in writing and at any time, except where uses or disclosures have already been made based upon my original permission. I might not be able to revoke this authorization if its purpose was to obtain insurance.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that Medical Records and information used or disclosed with my permission may be re-disclosed by a recipient and no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create Medical Records for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient (if filling out electronically, type your name, you will have the opportunity to sign at the end):

Client Full Name:

If the patient is unable to sign use the signature area below

The patient is unable to sign due to (check one)

☐ Being a Minor (complete the statement below)

The Patient is _____ years old and considered a minor under state law:

☐ Being Incapacitated (please explain below)

Patient is incapacitated due to:

☐ Other (please explain below)

Signature of Representative (if filling out electronically, type your name, there will be an option to sign at the end):

Date:

Printed Name of Representative:

Relationship to Patient (check one)

☐ Parent

- [ ] Guardian
- [ ] Spouse
- [ ] Other (please explain below)

Explain other: