Hope & Healing Counseling Services, LLC

Authorization for Use or Disclosure of Protected Health Information (PHI)

I, _____, hereby voluntarily authorize the disclosure of protected health information from my medical record. My date of birth is _____.
(MM/DD/YYYY)

The information is to be disclosed by:
Name of Facility or Agency

Hope & Healing Counseling Services, LLC
103 W. 2nd Street Suite 5
Howell, NJ 07731
732-534-5375

And is to be disclosed to:
Name of Person/Organization/Facility

Phone:

The purpose or need for this disclosure is:

_____

The information to be disclosed from my health record: (check appropriate box(es))

☐ Entire record

☐ Only information related to (specify) _____

☐ Only the period of events from _____ to _____

☐ Other (specify) _____

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

☐ Alcohol/Drug Treatment/Referral ☐ HIV/AIDS – related treatment

☐ Sexually Transmitted Diseases

I understand that I may revoke this authorization in writing submitted at any time to the HIPAA Privacy Officer, except to the extend that action has been taken in reliance upon this authorization, this authorization was obtained as a condition of obtaining insurance coverage or a police of insurance or other law provides the insurer with the right to contact a claim under the policy. If this authorization has not been revoked, it will terminate one (1) year from the date of my signature unless I have specified a different expiration date or expiration event. _____.
Enter date of event if different from 1 year after date shown below.

I understand that Hope & Healing Counseling Services, LLC will not condition treatment or eligibility for care on my providing this authorization expect if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

I understand that information disclosed by this authorization may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule (45 CFR Part 164)

SIGNATURE OF CLIENT (REQUIRED IF CLIENT IS 14 YEARS OF AGE OR OLDER)	DATE
SIGNATURE OF PARENT/GUARDIAN OR OTHER AUTHORIZED REPRESENTATIVE OR WITNESS	DATE

If signed by Parent/Guardian/Authorized Representative/, please complete the following:

_____ _____ _____
Name Relationship to Individual Area Code & Phone number

_____ _____ _____ _____
Address City State Zip Code