Total Life Counseling, Inc.

AUTHORIZATION TO DISCLOSE OF PATIENT HEALTH INFORMATION

Patient Name: ____

Address: ____

Date of Birth: __________________________ Date of Request: __________________________

As required by HIPAA Privacy Regulations, protected health information may not be used or disclosed to a third party without patient authorization.

I hereby authorize ____________________________________ to: ☐ **release** ☐ **request** ☐ **exchange** my Protected Health Information to the following person, health care provider, or business associate:

Organization: ____

Name: ____

Address: ____

Telephone: ________________________________ Fax: ________________________________

Patient Health Information authorized to be disclosed:

☐ Clinical Information (assessment information, test results, diagnosis, treatment plans, progress notes, treatment summary, medication records, hospital records, etc.)

☐ Billing and appointment information

For the specific purpose of (please describe in detail): ____

____

This authorization extends to Patient Health Information placed in the individual's record after the authorization date but before it expires. I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond your control.

Effective dates for this authorization: _____/_____/_________through _____/_____/_________. This authorization will expire one calendar year from the effective date unless otherwise specified.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of the Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

____ ______________________

Signature of Patient or Patient's Authorized Representative Date