Authorization for Use or Disclosure of Protected Health Information

Date: _____

Name: _____

Birth Date: _____ Last 4 Numbers Social Security # ☐☐☐☐

_____
Street Address Apt #

_____
City State ZIP

I authorize the use and/or disclosure of my protected health information (PHI) described below - please check box describing information and write in any other information not included in a check box

☐ All Records ☐ Psychotherapy/Asessment Notes

☐ Billing Information

☐ Other – please describe the other information in this box:

Authorization for Sensitive Information

I understand that my records may contain information related to history, diagnosis, and/or treatment of HIV (AIDs virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment and Genetic Information. If my records contain any such information I authorize the use or disclosure of that information only if I check a box below next to the type of information.

☐ HIV (AIDS virus) or other sexually transmitted diseases

☐ Psychiatric disorders and treatment

☐ Drug and/or alcohol abuse

☐ Genetic Information

My authorization of the use and/or disclosure of the information described above covers the following dates of treatment:

from _____ through _____

or

☐ all dates

I authorize the following Organization to *use and/or disclose* my protected health information described above:

☐ Balance Counseling and Wellness

or

☐ _____
Name of Provider/Institution/Organization

Authorization for Use or Disclosure of Protected Health Information

I authorize the following Organization to *receive* the use or disclosure of my protected health information described above:

☐ Balance Counseling and Wellness

or

☐ _____

Name of Provider/Institution/Organization

The purpose for which I am authorizing this use or disclosure is:

☐ At My Request

(At the request of an individual is sufficient when an individual initiates the authorization and does not, or elects not to, provide a statement of the purpose)

or

☐ Continued Medical Care ☐ Legal Purposes ☐ School

☐ Personal use ☐ Insurance Claim ☐ Military

☐ Social Security/Disability Determination ☐ Insurance Application

☐ Other – please describe the other information in this box:

This Authorization does not authorize use or disclosure of Psychotherapy Notes, Sale of Protected Health Information or uses and disclosures of Protected Health Information for Marketing purposes.

Expiration Date or Event of this Authorization

This authorization shall be valid - unless I revoke it earlier in writing - until:

Check one box

☐ The following date: _____

or

☐ When the following event occurs (please describe):

I understand

1. I may revoke this authorization at any time by giving Balance Counseling and Wellness notice of my revocation in writing. Balance Counseling and Wellness will furnish me with a form to make my revocation but I do not have to use that form to make my written revocation.
2. My revocation of this authorization will not apply to information used or disclosed as permitted by this authorization before I give Balance Counseling and Wellness written notice of my revocation.
3. Balance Counseling and Wellness may not condition my treatment or payment, enrollment or eligibility for benefits on whether I sign this authorization.

Authorization for Use or Disclosure of Protected Health Information

4. Information disclosed as permitted by this authorization may be re-disclosed by persons who receive it and is no longer protected by federal health information privacy law.
5. I may be charged a reasonable fee for any copies I have requested. Prices are established in accordance with WAC 246-08-400 and are available upon request from office staff.

I have read and understand this Authorization for Use or Disclosure Protected Health Information, signed it voluntarily and received a copy.

Signature, Individual/ Personal Representative _____

Name, Personal Representative (if any) _____

Personal Representative's Authority to Act _____

☐ Identity of the Individual verified

Or

☐ Identity, Authority to Act of Personal Representative verified

Received and confirmed for Balance Counseling and Wellness by:

_____

Signature Printed Name and Title