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HIPPA AUTHORIZTION FORM

I _____, whose date of birth is_____, authorize

_____to disclose to and/or obtain from_____

the following information

Description of Information to be Disclosed (*Client should initial each item to be disclosed*)

_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Psychological Evaluation
_____Treating information
_____Educational Information
_____Presence/Participation in Treatment
_____Continuing Care Plan
_____Progress in Treatment
_____Other_____

Purpose

The purpose of this disclosure is to improve assessment and treatment planning, share information relevant to treatment an when appropriate, coordinate treatment service. If other purpose, please specify_____

Revocation

I understand that I have the right to revoke this authorization in writing, at any time by sending written notification to_____ at the above address. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless revoked sooner, this authorization expires on _____
or as otherwise indicated_____

Conditions

I further understand that_____will not condition my treatment on whether I gave authorization for the requested disclosure. However, it has been explained that failure to sign the following consequences_____

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, I reserve the right to disclose information as permitted by this authorization in any manner that I deem to be appropriate and consistent with the applicable law, including but not limited to, verbally, in paper format, or electronically.

Redisclosure

I understand that there is a potential that the protected health information (PHI) that is disclosed pursuant to this authorization may be redisclosed by the recipient an the protected health information will no longer be protected by HIPPA privacy regulations, unless state law applies that is more strict than HIPPA and provides additional privacy protection. Other types of information may be re-disclosed by the recipient of the information in the following
circumstances_____
_____

I will be given a copy of this authorization for my records.

Signature of Client Date

Signature of Parent, Guardian, or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual. Attach appropriate documentation (power of attorney, temporary orders, healthcare surrogate, etc.).
_____
_____

_____Check here if client refuses to sign authorization

Signature of Therapist Date