HIPAA Privacy Authorization Form

****Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)****

1. Authorization

□ I authorize _____ (healthcare provider) to use and disclose the protected health information described below to Brenda Sallee at LifeSong Christian Counseling .

AND/OR

□ I authorize Brenda Sallee at LifeSong Christian Counseling to use and disclose the protected mental health information described below to _____.

2. Effective Period

This authorization for release of information covers the period of healthcare including **all past, present, and future periods** unless otherwise specified below. I, _____ (patient), allow *only* _____ information to be shared between the specified healthcare professionals named above for the time period of _____.

3. Extent of Authorization

a. □ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

****OR****

b. □ I authorize the release of my complete health record with the exception of the following information:
□ Mental health records
□ Communicable diseases (including HIV and AIDS)
□ Alcohol/drug abuse treatment
□ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until the client provides a written request for the release of information to cease or there is an end date listed above.

6. I understand that I have the right to revoke this authorization, in writing,

at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

_____

Client Signature

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

_____

Client Signature

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____

Signature of patient or personal representative Date

_____

Printed name of patient or personal representative Relationship to client