HIPAA AUTHORIZATION TO RELEASE OR OBTAIN HEALTH INFORMATION

Please complete all sections. Incomplete forms cannot be accepted.

Section I: Client Information
I, _____ (client name), Date of Birth_____, authorize _____(Practice) to share the information listed in **Section II** with the person(s) or organization(s) named in **Section IV.**

Section II: Information to Be Shared
I authorize the release of the following health information (check one):
□ My full health record, including but not limited to mental health diagnosis, treatment notes, billing, and appointment history.
□ Only the following parts of my record (check any that apply):
□ Mental health diagnoses and treatment □ Medication information □ Progress notes
□Appointment history and billing □ Other (please specify): _____

Section II: Dates of Information to be Shared
This authorization is for the following dates (check one):
□From _____to _____ □ All service dates

Section III: Purpose for Sharing Why (Check one or write in your reason):
□ At my request □ Coordination of care □ Legal/Court-related purposes □ Insurance □ Other: _____

Section IV: Who May Receive My Information
I give permission for my health information to be shared with:
Name/Relationship/Organization *(if applicable*): _____ Phone or email: _____
Fax *(if applicable)* _____
Note: The entities above may not be subject to HIPAA privacy laws and may re-disclose the information.

Section V: How Long Is This Authorization Valid?
This authorization will remain in effect until satisfaction of the need for disclosure, for specified dates, or in 365 days from the date of signature unless I have provided revocation.

I understand that:
(1) If my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health information. **(2)** I do not need to give any further permission for the information detailed in Section II to be shared with the person(s) or organization(s) listed in **Section IV. (3)** Failure to sign/submit this authorization or cancellation of this authorization will not prevent me from receiving treatment or benefits I am entitled to receive, provided this information is not required to determine eligibility for those treatments or benefits or to pay for the services I receive. **(4)** I may inspect or obtain a copy of the health information that I am being asked to disclose. **(5)** My signature on this form is strictly voluntary **(6)** I understand that I can revoke this authorization in writing at any time by completing a Revocation Form.

Section VI: Signature
Client Signature: _____ Date:_____
Client Print Name: _____

If signing on behalf of the client (e.g., parent, legal guardian), please complete below:
Name of Person Signing: _____ Relationship: _____
Signature: _____ Date: _____
Legal Authority (e.g., parent, guardian, POA):_____