AUTHORIZATION to USE, DISCLOSE, & SHARE Protected Health Information (PHI)

Dr. Kracke & Associates, P.A.

422 17th Street

Lewiston, ID 83501

Phone: (208) 743-4680 Fax: (208) 743-1756

1. I am completing this form to allow the use and sharing of protected health information regarding:

   Name: _____ Date of Birth: _____

2. I authorize Dr. Kracke and Associates, P.A. to share and/or receive information with/to/from this

   Person/Organization: _____

   Mailing Address: _____

   _____

   Phone #: _____ FAX #: _____ Email: _____

   ___ I grant permission for this information to be sent via electronic mail (initial if you agree).

3. To USE, SHARE, and/or DISCLOSE the following information:

__ Treatment records for physical &/or psychological illness or drug/alcohol abuse

__ Admission/Discharge summaries

__ Psychological evaluations, reports, assessments, treatment notes, summaries &/or other documents with diagnoses, prognoses, recommendations, test results, behavioral observations completed by any staff member or the patient, or similar documents

__ Treatment, recovery, rehabilitation, aftercare plans &/or other similar plans

__Social, family, educational &/or vocational histories

__ Social work assessments and plans

__ Progress and case notes

__ Information about how the patient's condition affect(s/ed) his/her ability to work &/or to complete activities of daily living

__ Vocational reports

__ Billing records

__ HIV-related information &/or drug/alcohol information contained in these records will be released under this authorization **unless** indicated here with initials _____

__**Any/All information my therapist deems appropriate**

4. **DO NOT RELEASE THE FOLLOWING ITEMS**: _____

   _____

5. *Dates of Care included:* ALL DATES OF SERVICE **or** From: _____ To: _____

6. This information will be used/disclosed for the following purposes: _____

7. I understand and agree that this Authorization will be valid and in effect for 12 months or until _____ (if left blank, this will expire 12 months from date signed). I understand that after that date no more of this information can be used or released to the person or organization unless a new authorization is signed.
8. I understand that I can cancel this authorization at any time by sending a letter to Dr. Kracke & Associates. If I do this, it will prevent any releases after the date the letter is received but cannot change the fact that some information may have been sent prior to that date.
9. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from Dr. Kracke & Associates, nor will it affect my eligibility for benefits.
10. I understand that I may inspect and have a copy of the health information described in this authorization.
11. I understand that if the person/organization receiving this information is not a health care provider or health insurer, the information described above may be re-disclosed and no longer protected by HIPAA regulations which are binding on health care related organizations
12. I understand that Dr. Kracke & Associates has the right to receive compensation for the use of disclosure of my health information. The arrangement has been explained to me and I understand and accept it. OR Does not apply ____.
13. I affirm that everything in this form which was not clear to me has now been explained. My signature below indicates that I now understand all of the above.
14. If my child is over the age of 14, he/she must sign consent for the provider and staff to provide information about their treatment.

_____	_____	_____
Signature of client/legal representative/parent	Printed Name of client/legal representative/parent	Date
_____	_____	_____
Signature of child over 14 years old	Printed name of child over 14 years old	Date