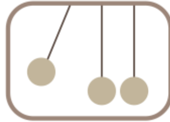

Birthstone HIPPA Form for Release of Medical Record Information

Client Name_______________________________________ **Date of Birth**___________

Email ________________________ **Telephone**______________________

I hereby authorize **Birthstone Trauma Healing** to use or disclose the protected health information for the above named client as described below.

The following person, physician, group or entity may receive disclosure of protected health information:

Name and contact information: ____

Unless you sign here, NO information about alcohol/substance abuse, HIV/AIDS or mental health issues, including ADD and ADHD, will be disclosed. *One signature required here*(ANY PATIENT AGE 14 AND OVER MUST PROVIDE THE SIGNATURE HERE)

YES, disclose this information____ NO, do NOT disclose this information____________________________________

I understand that the information used or disclosed may be subject to re-disclosure by the person or facility receiving it and then would no longer be protected by federal privacy regulations.

I may revoke this authorization by notifying ___________________________________ in writing of my desire to revoke. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of the above named patient on whether or not I sign the authorization.

My purpose for/intended use of this information is ________________________________ This authorization will expire in one (1) year after the date on this request.

Signature of patient if 18 years of age or older Date

____ _________________________________

Signature of patent or guardian for minor child Date

____ __________________________________

Is there a custody issue with this child? ☐ - Yes ☐ - No Initial________