ACTUALIZE PSYLUTIONS HIPAA Health Insurance Portability & Accountability Act, Privacy Authorization

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

1. Authorization

I authorize *Actualize Psylutions/Carroll Solutions, LLC* (healthcare/mental health counseling/family therapy provider) to obtain and/or use and/or disclose the PHI described below to _____ *(If applicable, third party/parties related to client care; if not applicable, leave blank).*

2. Effective Period

This authorization for release of information covers the period of provide-care for all past, present, and future periods.

3. Extent of Authorization

I authorize the release of all records, my complete treatment record (including records relating to mental healthcare, communicable diseases, HIV/AIDS, *related* legal/court (state, county, federal/other applicable) records, and treatment of alcohol and/or drug abuse).

4. This medical/mental health/psychological/other information may be used by the person I authorize to receive this information for care (total) treatment or consultation, non-profit/for-profit service related inquiries, related legal matters, billing or claims payment, or other purposes as I may direct or are as considered reasonable by like professionals.

5. This authorization shall be in force and effect until at least 10 years post termination of services, as required by Washington State care records law: RCWs > Title 70 > Chapter 70.41 > *Section 70.41.190*.

6. I understand that I have the right to revoke this authorization, in writing, at any time. 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, the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment (as applicable)/or volunteer agreement (verbal/including partnering-agency-initiated), enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

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 Client, or of personal representative **Date**

_____

Printed name of Client, or of personal authorized representative & relationship to Client