Healing Paths Intuitive Therapy

AUTHORIZATION FOR ACCESS, USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Client Name (please print) _____

Birthdate _____ **Social Security No** _____ **Phone:**_____

Address _____

City _____ **State** _____ **Zip Code**_____

I, _____ **, authorize and request Healing Paths Intuitive Therapy** X **Obtain From and/or** X **Release To the information specified below:**

Person/Organization Health Insurance

Address _____**City** _____

State _____ **Zip Code** _____**Phone #** _____**FAX #** _____**E-Mail**_____

Information to be Released and/or Obtained

- ☐ Duration of program involvement and attendance
- ☐ Summary of treatment participation
- ☐ Evaluations and recommendations
- ☐ Medical History
- ☐ Psychosocial History
- ☐ Alcohol/Other Drug History
- ☐ Legal History
- ☐ Urinalysis/Breathalyzer results
- ☐ Psychological/Psychiatric testing and evaluation
- X Other (specify) verify insurance coverage, eligibility, co-pays and exclusions standard to your care.

Purpose(s) for Which Information is to be Released and/or Obtained

Please explain why you are requesting access, use or disclosure to the above mentioned health record:

X☐ Coordination of Treatment X Insurance Verification Income Verification ☐ Legal ☐ Education

☐ Obtain information concerning client's report of history/current behavior ☐ Other (describe) **benefits to pay directly to provider. Medical information and data released to health insurance**

Health Records for dates of treatment I received from (date) _____through (date) _____or ☐ discharge

I specifically authorize the release of records that may include protected confidential information regarding:

X Drugs or alcohol use/abuse X Mental Health

Healing Paths Intuitive Therapy may impose fees to cover the cost of labor, copying, postage, and preparation of the requested information. The current fee structure is $1.00 per page for the first 30 pages, $.50 per page for pages 31 through 100, and $.25 per page for all pages over 100. I agree to the above imposed fees for providing copies of the requested information? X YES ☐ NO

Expiration: This authorization is effective for X one year OR until (day, month, year) _____or expiration of event (e.g. completion of a course of treatment or end of research study) but no longer than 1 year from the date on which it is signed.

Revocation: I understand that I may revoke this authorization at any time by notifying Healing Paths Intuitive Therapy in writing. I understand that if I revoke this authorization, it will not affect any actions that Healing Paths Intuitive Therapy took before it received my revocation letter.

Re-disclosure: I understand that the information used and/or disclosed according to this authorization may no longer be protected by federal privacy law (also known as HIPAA) and the recipient of your health information may potentially re-disclose it. However, Federal Law (42 CFR Part 2) for Alcohol/Drug abuse, and State Law (Iowa Code Ch. 228 & 141) for Mental Health, and HIV/AIDS treatment, prohibit information disclosed from records protected by these laws from being re-disclosed, even to the patient, without the specific written consent of the patient or as otherwise permitted by such law and/or regulations. A general authorization for the Release of Medical or Other Information is **NOT** sufficient for these purposes. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. Civil and Criminal Penalties may attach for unauthorized disclosure of alcohol/drug abuse, mental health, or HIV/AIDS information.

Signature of Client X_____ **Date** _____

Signature of Client Representative (If applicable)_____**Date** _____

Signature of Therapist: _____**Date** _____