Kathy Wei, LCSW76613, RYT® 200
242 West Main Street, Suite 200F, Tustin, CA 92780
Phone: (949) 328-6696

HIPAA Privacy Authorization Form

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

1. Authorization

I ______________________________________ (print your name) authorize Kathy Wei, LCSW to

☐ **disclose** the protected health information described below to

☐ **obtain** the protected health information described below from

☐ **exchange** the protected health information described below with

_____________________________________ (individual/organization seeking the information).

2. Effective Period

This authorization for release of information covers the period of healthcare from:

☐ From ___________________ to ____________________.

OR

☐ All past, present, and future periods.

3. Extent of Authorization

☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

☐ I authorize the release **only** following information for ☐ Mental health records, ☐ Alcohol/drug abuse treatment :

☐ treatment summary

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- [ ] history/intake
- [ ] diagnosis
- [ ] psychological test results
- [ ] psychiatric evaluation/medication history
- [ ] dates of treatment attendance
- [ ] other (specify)

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until ___________________ (date or event), at which time this authorization expires.

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

7. I understand that my treatment, payment, 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.

Print Name: ____________________________________ Date: ________________________

Social Security Number: __________________________ Date of Birth: _________________

Address: ______________________________________ Phone Number: _______________

Signature: ____

(Client/Parent/Conservator/Guardian)