Kansas HIPAA Privacy Authorization Form
NEW BEGINNINGS BEHAVIORAL HEALTH, INC

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

I hereby authorize New Beginnings Behavioral Health, Inc to use and/or disclose the
[Name of Health Care Provider]

protected health information described below to _____ _____
Name of Patient **Date of Birth**

Authorization for **RELEASE** of Information. Covering the period of health care from
☐ _____ to _____ **OR**

☐ **All** past, present, and future periods:

OR

☐ I hereby **authorize the Release of my complete health record with the exception of the following information**:

☐ Mental health progress notes
☐ Diagnoses
☐ Alcohol/drug abuse treatment
☐ Other (please specify): _____

☐ I give permission for all verbal communication concerning my care.

This medical information may be used by _____,
Name of Doctor's office/ facility

_____ _____
Address & phone # Fax Number

I authorize to receive this information for
medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

This authorization shall be in force and effect until 1 YEAR from date, at which time this authorization expires. [Date or Event]

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.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

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 Patient or Personal Representative Date

_____ _____
Print Name of Patient or Personal Representative Relationship to Patient