Marci Garcia Mental Health Services, PLLC
704 Bensdale Rd, Pleasanton, TX 78064
8306310288
8306310299
contact@thepsychnp.net
thepsychnp.net

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

1. Full Name:

_____

Date of Birth: _____ Last 4 of SSN: _____

I. My Authorization:

I authorize the following using or disclosing entity:

2. Provider Name:

_____

Provider Phone Number: _____ Provider Address: _____

3. **The above entity is authorized to use or disclose the following health information. Please check box next to your selection:**

☐ All of my health information. ☐ All Labs/diagnostic testing. ☐ Labs/EKGs only.
☐ I decline to have my records released. ☐ Other: (Please specify dates or information below.)

_____

4. **The above entity is authorized to disclose this health information on my behalf to the following recipient: Marci Garcia Mental Health Services, PLLC 704 Bensdale Rd, Pleasanton, TX 78064 Phone: 8306310288 Fax: 8306310299 Email: contact@thepsychnp.net**

☐ At my request. ☐ Other: (Please specify below.)

_____

This authorization ends one year from the date of this form unless otherwise specified OR when the following even occurs:

_____

II. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party. I understand that uses and disclosures already made based upon my original permission cannot be taken back. I understand that it is possible that information used or disclosed with my permission may be redisclosed by the recipient and is no longer protected by the HIPAA Privacy Standards. I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization. I will receive a copy of this authorization after I have signed it if requested.

III. Additional Consent for Certain Conditions

Separate consent must be given before this information can be released.

5. This medical record may contain information about physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment.
   - ☐ I consent to have the above information released.
   - ☐ I do not consent to have the above information released.

   This medical record may contain information concerning HIV testing and/or AIDS diagnosis or treatment.
   - ☐ I consent to have the above information released.
   - ☐ I do not consent to have the above information released.

   Patient:

   _____
   Signature

   Guardian/Power of Attorney (if applicable)

   _____ _____
   Signature Date

6. Print Guardian Name:

   _____

This document shall be effective for 1 year after date indicated. Any photocopy of this document shall serve as the original.