# AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

CLIENT NAME: _____ DOB: _____

Information to Be Released:

____ Any and all information pertaining to treatment ___ Information Specified Below

_____

_____

I, the undersigned, authorize and request H.I.S. Counseling, to

____ release information to ___ obtain information from

_____

Name, Facility

_____

Complete Mailing Address

_____

Telephone / Fax Numbers Email address

This is a: ___ one-time consent ___ continuing consent

For the purpose(s) of: ___ treatment or consultation ___ The request of the client

I understand that my records are protected under Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time by submitting a notice in writing to the Facility Privacy Officer except to the extent that action has been taken in reliance on it (e.g. probation, parole, etc.) and that in any event this consent as described below. I hereby release any person, firm, physician, clinic, hospital, or agency, public or private, from any liability for information to this authorization. I waive my right to privileged communication and confidentiality to H.I.S. Counseling. The information to be released and received has been discussed with me.

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and therapists are hereby released from and any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

I understand I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form unless specified under the purpose indicated above.

I understand that certain medical records (including any alcohol abuse information*, drug abuse information*, and HIV information) may be protected by Federal Laws and Regulations. *42 U.S.C. 290-3 and 42 C.S.U. 290ee-3 for Federal Laws and 42 CFR Part 2 for Federal regulations.

**THIS CONSENT EXPIRES NINETY (90) DAYS AFTER MY FINAL THERAPY SESSION WITH THIS FACILITY**

_____ _____

Client / Parent / Guardian Signature Date

_____

Relationship to the client