AFFINITY
COUNSELING CENTER

Release of Information

It is my understanding that Congress passed a law entitled the Health Insurance Portability and Accountability Act ("HIPAA") that limits disclosure of my or my child's protected medical information. This authorization is being signed because it is often beneficial for my counselor to be able to discuss needed information with family, close friends and other individuals involved in my care. I understand that I have a choice in who my counselor discusses my protected health information with and how it is discussed.

Pursuant to 45 CFR 164.501 (a)(I)(iv) a covered entity (my therapist) is permitted to disclose protected health information pursuant to and in compliance with this valid authorization under 45 CFR sec. 164.508.

Authorization

Client Name: _____Date of Birth: _____

I, _____ authorize providers and staff at Affinity Counseling to release the following information:

- ☐ Appointment times and scheduling
- ☐ General information related to appointments.
- ☐ All health care information
- ☐ Billing information
- ☐ Counseling records and documentation
- ☐ Information related to substance abuse.
- ☐ Information related to HIV and/or AIDS.

To the following authorized person or agency:

Name: _____

Address: _____

Phone: _____

Relationship: _____

This authorization shall terminate on the first to occur (1) two years following my death or (2) upon my written revocation actually received by the covered entity. Proof of receipt of my written revocation may be by certified mail, registered mail, facsimile, or any other receipt evidencing actual receipt by the covered entity. This revocation shall be effective upon the actual receipt of the notice by the covered entity except to the extent that the covered entity had taken action in reliance on it. This authorization is not affected by my subsequent disability or incapacity.

By signing this authorization, I acknowledge that the information may be subject to re-disclosure by the person or persons name that is written above, and the information once disclosed will no longer be protected by the rules created in HIPAA. No covered entity shall require my authorized persons to indemnify the covered entity or agree to perform any act in order for the covered entity to comply with this authorization.

I understand that when my records are held jointly such as in the case of couples or family therapy my consent only allows the release of information directly related to myself and all other elements of the record will be redacted by the therapist.

Waiver and Release

I hereby release any covered entity that acts in reliance on this authorization from any liability that may accrue from releasing my protected medical information and for any actions taken by my authorized persons.

_____ _____

Signature *Date*

_____ _____

Printed Name *Relationship to client*

_____ _____

Affinity Staff Signature *Date*