LaTonya McCurry
Counseling Services, LLC

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)

Client Information

_____

Patient Name

DOB: ____/____/_____

_____

Patient Address

_____

Patient Phone Number

Authorization

I, _____ (patient name and date of birth) authorize

_____ (healthcare provider) to use and disclose the protected health information described below to _____ (recipient/ "authorized person")

Effective Period

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

_____ to _____ (not to exceed one year from date of signature)

Extent of Authorization

- ☐ **I authorize the release of my complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS and treatment of substance abuse)**
- ☐ **I authorize the release of my complete health record with the exception of the following information:**
  - ☐ **Mental health record**
  - ☐ **Substance abuse treatment**
  - ☐ **Communicable diseases (including HIV and AIDS)**
  - ☐ **Other (please specify): _____**

This medical information may be used by the authorized person for medical treatment or consultation, billing or claims payment or other purposes as I specify.

I understand that this authorization is voluntary. I also have the right to revoke this authorization, in writing, at any time without regard to the above expiration date. 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.

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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**

_____ _____
Printed name of patient or personal representative/ relationship to patient **Date**

If signed by a personal representative:
(a) Print your name: _____
(b) Indicate your relationship to the client and/or reason and legal authority for signing:
Patient is: □ minor □ incompetent □ disabled □ deceased
Legal authority: □ parent □ legal guardian □ representative of deceased

LaTonya McCurry_____ _____
Signature of Witness **Date**