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REQUEST/AUTHORIZATON FOR RELEASE OF INFORMATION

HIPAA PRIVACY AUTHORIZATION FORM
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.

I. AUTHORIZATION

I,____________________________________,__________________________________ hereby authorize Estefanía Simich, LCPC of Zen for Change, LLC to release information contained in my client records to the following individual(s) and/or organizations(s), and only under the conditions below:

1. Name of person(s), organizations(s), address to who disclosure is to be made:

____ _____________________________________

2. Information to be disclosed:

□ Treatment Summary

□ Entire Record:____

□ Other :____

□ Diagnosis □ Attendance □ Progress □ Prognosis □ Drug/Alcohol History

□ Mental Status Exam □ Discharge Summary

II. PURPOSE

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct, including but not limited to the following:

□ Provision of Mental Health Services □ Billing Purposes □ Aftercare Planning

□ Continuity of Treatment □ Family Involvement □ P.O./Attorney/Judge/Court

III. EFFECTIVE PERIOD

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

______________________to_______________________ ______________ (Initial)

OR

All past, present and future periods. __________ (Initial)

This authorization shall be in force and effect until ______________________________ (date or event), at which time this authorization expires. (If not specified, authorization expires 90 days after date of last treatment.)

IV. EXTENT OF AUTHORIZATION

___________ (Initial) I authorize the release of my complete health records, including records relating to mental healthcare, communicable diseases, HIV or AIDS, and/or treatment of alcohol or drug abuse.

___________ (Initial) I authorize release of my complete health record with the exception of the following information:

_______ Mental health records

_______ Communicable diseases (including HIV and AIDS)

_______ Alcohol/drug abuse treatment

_______ Other (please specify): __________________________

V. MISCELLANEOUS/ACKNOWLEDGMENT

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.

____
Client (Parent/Guardian) Signature/Date

____
Relationship to Patient

____
Clinician Signature/Date