Smithson Counseling

HIPAA Release of Information

Authorization for Use or Disclosure of Protected Health Information

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Authorization:

I authorize (Smithson Counseling/ Andy Smithson, LCSW) to use and disclose and exchange the protected healthinformation described below with _____ (individual/organization seeking/sharing the information).

Address: _____

Phone: _____

Fax/Email: _____

Effective Period:

Thisauthorization for release of information covers the period of: a. _____ to _____ OR b. □ all past, present, and future periods.

Extent of Authorization:

I authorize the release of the following medical/mental health records for purposes of effective assessment and/or treatment.

□ Mental health records: _____

□ Medical Records: _____

□ Alcohol/drugabusetreatment : _____

□ Other(please specify):_____

This medical information may be used by the person I authorize to receive this information fo rmedica l treatment, Mental Health assessment and treatment or consultation, billing or claims payment, or other purposes as I may direct.

This authorization shall be in force and effect until_____(dateorevent), at which time this authorization expires.

I understand that I have the right to revoke this authorization, in writing, at anytime. 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.

Signature of patient or personal representative: _____

Printed name of patient or personal representative and his or her relationship to patient:

_____

Date: _____