YOUR LOGO HERE

COMPANY NAME
ADDRESS
PHONE/FAX
EMAIL
WEBSITE

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION UNDER FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

I, or my authorized representative, hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may be subject to re-disclosure and may no longer be protected by federal privacy regulations, including HIPAA. I hereby release the organization providing this information from any legal responsibility or liability for disclosure of this information to the extent indicated and authorized herein. I give permission for COMPANY. to discuss my past, current and future medical care/needs with physicians, therapist, psychiatrist/psychologist/ counselor, and other healthcare providers. I specifically and expressly authorize a photocopy of this authorization as though it were an original.

Client Name: _____ Date of Birth: _____ SS#: _____

Client Address: _____

Persons/organizations receiving the information: (Send to)
COMPANY, P.O. Box 1161, Hendersonville, NC 28793, Phone: 828.698.8486, Fax: 888.412.2181

Specific description of information, covering health care from_____to _____.
Complete health records and bills (prescription bills, history and physical, discharge summary, operative reports, consultation reports, radiology and imaging reports), excluding all images (x-rays, photographs, etc.)
Other (please specify) _____

The client or client's representative must read and initial the following statements:

1. I understand that this authorization will expire on _____. Initials: _____

2. I understand that I may revoke this authorization, in writing, at any time. Initials: _____

3. I understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by a recipient of such information. It is possible that once disclosed, the privacy of the information will no longer be protected under federal medical privacy law. Initials: _____

4. I understand the data released may include material protected by law including mental health, drugs and alcohol, HIV/AIDS and other communicable diseases, and genetic testing. Initials: _____

I have read and understand the information in this Authorization.

X_____ Date: _____
Signature of client or client's representative

Printed name of representative: _____ Relationship: _____