Authorization for Use or Disclosure of Protected Health Information

Kairos Psychotherapy Northwest
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This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Full Name: _____ Date of Birth: _____

I. My Authorization

I authorize the following using or disclosing party:

_____

to use or disclose the following health information:

☐ - My complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse)

☐ - My health information relating to the following treatment or condition:
_____

☐ - My health information covering the period from _____ (date) to _____ (date)

☐ My complete health record **with the exception of** the following information (check all that apply):

☐ Mental health records

☐ Communicable diseases (including HIV and AIDS)

☐ Alcohol/drug abuse treatment

☐ Other (please specify): _____

The above party may disclose this health information to the following recipient:

Name (or title) and organization _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____ Email _____

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

☐ _____ to _____.
OR

☐ all past, present, and future periods.

The purpose of this authorization is (check all that apply):

☐ - 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.

☐ - At my request

☐ - Other: _____

This authorization shall be in force and effect until:

☐ - On (date)_____

☐ - When the following event occurs: _____

at which time this authorization expires.

II. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party, payment, enrollment, or eligibility for benefits may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

Signature of Patient: _____ Date: _____

If the patient is a minor or unable to sign, please complete the following:

☐ - Patient is a minor: _____ years of age

☐ - Patient is unable to sign because: _____

Signature of Authorized Representative: _____

Date: _____

Print Name of Authorized Representative: _____

Authority of representative to sign on behalf of the patient:

☐ - Parent ☐ - Legal Guardian ☐ - Court Order ☐ - Other: _____

III. Additional Consent for Certain Conditions

This medical record may contain information about **physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment**. Separate consent must be given before this information can be released.

☐ - I consent to have the above information released.

☐ - I do not consent to have the above information released.

Signature of Patient or Authorized Representative: _____

Date: _____ Time: _____

IV. Additional Consent for HIV/AIDS

This medical record may contain information concerning **HIV testing and/or AIDS diagnosis or treatment**. Separate consent must be given to have this information released.

☐ - I consent to have the above information released.

☐ - I do not consent to have the above information released.

Signature of Patient or Authorized Representative: _____

Date: _____ Time: _____