Patient/Client Authorization for Use or Disclosure of Protected Health Information - Confidential Records and Information Consent Form

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a practice may not use or disclose your individually identifiable health information without your authorization, except as provided in our Notice of Privacy Practices. Your completion of this form means that you give permission for the use and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete those sections detailing the information to be released, and the purposes for the disclosure.

* **Patient/Client's name:** ____

Address: ___________________________________ **Phone**:_______________

Name of Parent/Guardian (if applicable): ________________________________

* I authorize Denise Booth LPC, NCC of Healing Journeys Therapy LLC to (check one or both):

Send/Release _________

Receive ________

* The following information/records are to be released (please check with an X all that apply and draw a line through items NOT to be released):

Mental health evaluations (with diagnoses, prognoses, recommendations): _________

Developmental and/or social history: _________

Treatment summary (with diagnoses, prognoses, course of treatment & duration): ___________

Other (please specify): ____

* Dates of information/records to be released (all episodes of care are to be included unless specific dates are indicated; state “all” if you wish all dates to be included): ______________________________

*Specify to who (person/organization) the information/records should be sent to:

* To (person/organization): ____

*Address: ____

* Phone: ____

* Your relationship to patient/client (please check one):

Self ____________

Parent/legal guardian____________

Personal representative____________

Other(please specify) _________________________

* I authorize the release of the above information/records for the following purposes (please check with an X all that apply):

Planning appropriate treatment, evaluation, or care ________________

Continuing appropriate treatment, evaluation, or care ________________

Determining eligibility for program or services _______________

Updating files _______________

Other (please specify): ____

* How do you want this information sent/released?

USPS-Mailing Address: ____

Other (e.g. telephone/verbal): ____

I understand that this information may be protected by Title 45 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 42 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice to Denise Booth LPC, NCC but that doing this will not bring back the information/records that were released before the date of revocation. I also understand that after 1 year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization. I understand that the source of the information/records has no control of it after it has left the Source's premises.

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

* Signature: ____________________________________

* Date: __________________

Witness signature (if patient is unable to sign): ____________________

Witness Date: ______________________

This form can be sent to: denise@healingjourneystherapyllc.com or mailed to:

Denise Booth LPC, NCC (Healing Journeys Therapy LLC)
PO Box 3086
Bethlehem, PA 18017