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AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

1. I am completing this form to allow the use and sharing of Protected Health Information about (Printed Name) _____, Address _____, Phone # _____, and Date _____.
2. I (Client or representative) _____ authorize _____ (Name of Therapist) to use or disclose the following information.
3. Dates of care included: From: _____ to: _____.
4. To this person or organization _____.
5. This information will be used / disclosed for the following purposes: _____.
6. I understand and agree that this authorization will be valid and in effect until _____ (enter a date or event upon which this authorization expires). I understand that after the date or event, no more of this information can be used or released to the person or organization unless I sign a new authorization like this one.
7. I understand I can revoke or cancel this authorization at any time by sending a letter to my Therapist. If I do this, It will prevent any releases after the date it is revoked but cannot change the fact that some information may have been sent or shared before that date.
8. I understand that I may inspect and have a copy of the health information described in this authorization and that a fee will be charged.
9. I understand that if the person or entity that received the information is not a healthcare provider or health plan covered by federal regulations, the information described above may be redisclosed and no longer protected by those regulations.
10. I understand that this professional will receive compensation for the disclose of my health information ranging from $10 to $25. I understand and accept it.
11. I confirm that everything in this form that was not clear to me has been explained and I believe I now understand all of it.

Description of personal representatives authority:_____.

NPP (short version) given to client on date: _____