Heart Centered Healing Connections

AUTHORIZATION FORM (HIPAA)

Authorization for Disclosure of Protected Health Information

1. **I authorize my healthcare practitioner and/or administrative and clinical staff to disclose my protected health information, as specified below, to:**

2. I am hereby authorizing the disclosure of the following protected health information:
   Outpatient Mental Health

3. This protected health information is being used or disclosed for the following purposes:
   Coordination of Care

4. This authorization shall be in force and effect until one (1) year after the date below at which time this authorization to disclose protected health information shall expire.

5. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to my healthcare practitioner, _____. I understand that a revocation is not effective to the extent that my healthcare practitioner has relied 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.

6. I understand that information disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by HIPAA or any other federal or state law.

7. My healthcare practitioner will not condition my treatment on whether I provide an authorization for disclosure except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

_____	_____
Name of Client, or Parent of Minor	Birth Date of client
_____	_____
Signature of Client, or Parent of Minor	Date
_____	_____
Witness	Date