

Authorization for Use and Disclosure of Protected Health Information

Release TO:	Name:	Phone	e:
	Address:		
	City:	State:	Zip:
	Medical/Financial Power of Attorney (if applicable):		
Release FROM	: Provider/Facility:		
		State:	
Patient or Indiv	vidual Identification:		
	Date of Birth:		
		State:	
-		Phone #:	
	quest (Must check one		
-	•	reatment Planning □Coordination of Se	rvices
	fication/Authorization		
		□Paper (hard copy) □Electronically via	· · · · · · · · · · · · · · · · · · ·
Information to	be released – Covere	ed Periods of Health Care (must che	ck one):
•	. ,	To (date):	
•	-	be released (check all that apply): □Psychiatric Progress Notes	☐Summary of Treatment Report
□Other:			
Drug and/or Ale I understand if my	cohol Abuse, and/or medical or billing record	Psychiatric, and Communicable/No contains information in reference to drug cohol abuse, communicable and/or non-co	and/or alcohol abuse or treatment,
sensitive informa	ation, I agree to its release	e. Check One: □YES □NO	
	medical or billing record	I contains information in reference to HIV//ome) testing and/or treatment, I agree to its	
Check One: □Y	∕ES □NO	***FORM CONTINUES ON OTHER SIDE***	

Time Limit & Right to Revoke Authorization Except to the extent that action has already been taken in reliance on this authorization, I can revoke this authorization at any time. Unless revoked, this authorization will expire on the following date or event: or not to exceed 1 year from date of signature.				
Re-disclosure I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 or state statute.				
Right to Refuse I understand that I do not have to sign this Authorization, and my treatment or payment for services will not be denied if I do not sign.				
Signature of Patient or Legal Guardian Who May Request Disclosure				
I understand that there may be a charge for copying my records. State law governs what the Releasing Entity may				
charge. I have read this form, and I understand and agree to the uses and disclosures of health information as described in this				
Authorization. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by State statute and/or 45 CFR §164.502 (a)(1). I hereby knowingly and voluntarily authorize Preferred Counseling to use and disclose protected health information specified above.				
Signature of individual or personal representative Date Time				
Printed name of individual's personal representative, if applicable:				
Rationale for serving as personal representative to the individual (eg., parent, legal guardian):				
Witness Signature (where legally required):				
TO THE PARTY RECEIVING THIS INFORMATION:				
This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR, Part 2) prohibit you from making any further disclosure of or without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. It is the exclusive responsibility of Preferred Counseling Staff to disclose this information to the consumer.				
OFFICE USE ONLY				
Verified by				
Identity of Requestor Verified via:				
□Photo ID □Matching Signature □Other, specify:				

Phone: 479-709-9880 Fax: 479-709-9887 Email: office@preferredcounseling.net
Office Hours: 9:00 - 5:00 Mon, Tues, Wed, Thurs rev

Copy of Power of Attorney (if applicable)? $\ \square$ Yes $\ \square$ No