PREFERRED COUNSELING

Authorization for Use and Disclosure of Protected Health Information

Release TO: Name:_____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Medical/Financial Power of Attorney(if applicable): _____

Release FROM: Provider/Facility: _____

Address: _____

City: _____ State: _____ Zip: _____

Patient or Individual Identification:

Printed Name: _____ Date of Birth: _____

Other Name(s) Used: _____

Address: _____

City: _____ State: _____ Zip: _____

Last 4 Digits of Social Security #: _____ Phone #: _____

Purpose of Request (Must check one):

☐Attorney/Legal ☐Billing/Payment ☐Treatment Planning ☐Coordination of Services

☐Insurance Certification/Authorization

☐Other (specify): _____

I Request My Records be Provided: ☐Paper (hard copy) ☐Electronically vial email

Email address: _____

Information to be Released – Covered Periods of Health Care (must check one):

☐Any and all ☐From (date): _____ To (date): _____

Please check type of information to be released (check all that apply):

☐Intake Assessment/Treatment Plan ☐Psychiatric Progress Notes ☐Summary of Treatment Report

☐Other:_____

Drug and/or Alcohol Abuse, and/or Psychiatric, and Communicable/Non-Communicable Diseases

I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse or treatment, psychiatric care in regards to drug and alcohol abuse, communicable and/or non-communicable diseases, and/or other sensitive information, I agree to its release. **Check One: ☐YES ☐NO**

HIV/AIDS Records Release

I understand if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release.

Check One: ☐YES ☐NO *****FORM CONTINUES ON OTHER SIDE*****

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

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 Personal Representative 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: _____

Copy of Power of Attorney (if applicable)? ☐ Yes ☐ No