Healthwise
behavioral health & wellness

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HIPAA AUTHORIZATION FORM
RELEASE OF INFORMATION

I, _____, DOB: _____, authorize _____ to disclose to and/or obtain information from _____, Fax # _____ the following information (Please check):

- ❑ Assessment
- ❑ Diagnosis
- ❑ Psychosocial Evaluation
- ❑ Psychological Evaluation
- ❑ Treatment Plan or Summary
- ❑ Current Treatment Update
- ❑ Testing Information
- ❑ Educational Information
- ❑ Presence/ Participation in Treatment
- ❑ Continuing Care Plan
- ❑ Progress in Treatment
- ❑ Other _____

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If other purpose, please specify: _____

_____

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to my provider at the above address. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this authorization expires in one year, or as otherwise indicated: _____

Conditions

I further understand that my provider will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: _____

_____

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

I understand that there is the potential that the protected health information (PHI) that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPPA privacy regulations, unless a State law applies that is more strict than HIPPA and provides additional privacy protections. Other types of information may be re-disclosed by the recipient of the information in the following circumstances: _____

I will be given a copy of this authorization for my records.

Signature of Client: Date:

Signature of Parent, Guardian, or Personal Representative Date: