Vickie George Counseling

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name _____ Date of Birth _____

Address _____ SSN _____

I hereby authorize _____, including agents and employees _____ to use or disclose the following individual's "protected health information": _____, as they may be covered under privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996" and as specified in this Authorization. I understand that "protected health information" includes records disclosed to the Individual's healthcare providers by health care providers and facilities who previously provided treatment to the Individual. I also understand that "protected health information" may include information and records protected under Federal Law (such as alcohol and drug abuse treatment information) and/or protected under State Law (such as regarding mental health treatment, mental retardation, privileged communications, communicable or infectious diseases, alcohol/drug abuse, AIDS or HIV.

INFORMATION TO BE USED OR DISCLOSED

I authorize _____to release the Individual's protected health information, including the Individual's complete Medical Record to _____, including agents and employees, and if to an entity, that entity's agents, employees, experts, and consultant including oral communication, clarification and explanation **and if regarding pending litigation: as pertaining to the following case**

Matter of _____ **v.** _____

Civil Action File No. _____

Currently pending in the following court _____

I understand the full and complete Medical Record will be provided unless I specify that only the following portions are to be copied and provided: _____
_____

PERSON(S) AUTHORIZED TO MAKE THE USE OR DISCLOSURE

I hereby authorize _____ named above, including his/her agents and employees, to make the uses and disclosures specified in this authorization.

RECIPIENT(S) OF USE OR DISCLOSURE

The Individual's Health Information and Records may be used by or disclosed to _____ _____, including his or her agents and employees.

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PURPOSE(S) OF THE USE OR DISCLOSURE

The purpose of the use or disclosure is to provide the Individual's Health Information and Records at the request of the individual signed below **or if litigation**, **for purposes of the following case:**

Matter of _____ **v.** _____
Civil Action File No. _____
Currently pending in the following court _____

I understand production of the Individual's Health Information and Records to the recipients is necessary to evaluate the claims and injuries asserted in this lawsuit.

This authorization will expire twelve (12) months from the date signed below. **If litigation, at the close of litigation, including all appeals, for the following case:**

Matter of _____ **v.** _____
Civil Action File No. _____
Currently pending in the following court _____

I understand that I may revoke this Authorization by submitting a written revocation to _____ _____. However, such revocation will not be effective with respect to any use or disclosure made by _____in reliance on this Authorization before _____ _____received my revocation.

I understand that _____ cannot condition, the Individual's treatment on whether or not I sign this Authorization.

I understand the Individual's Health Information and Records used or disclosed by _____ pursuant to this Authorization may be subject to re-disclosure by the recipient, in which case they might no longer be protected under HIPAA's Privacy Rule.

I hereby release _____and his/her agents, employees, partners, officers and directors, from any liability, damages and expenses arising in connection with its/their use or disclosure pursuant to this authorization.

_____ _____
Printed Name of Individual **Date**

_____
Signature of Individual

or

_____ _____
Personal Representative of Individual **Basis of Personal Representative's authority to sign for Individual**