HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

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This Authorization for Use or Disclosure of Health Information is required under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its implementing rules and regulations, and the Health Information Technology for Economic and Clinical Health Act ("HITECH Act") of the American Recovery and Reinvestment Act of 2009 ("ARRA") and its implementing rules and regulations, each as may be amended from time to time, including those regulatory amendments of the Department of Health and Human Services published at 78 Fed. Reg. 5566 (Jan. 25, 2013) ("HIPAA Final Omnibus Rule").

This form is for use when authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Client: _____
Date of Birth: _____

I. My Authorization

I, the client, authorize Jesse Huebner Counseling, LLC to disclose information about my treatment to the following party:
Name (or title) and organization_____
Address _____
City _____State _____Zip_____
Phone _____Fax _____Email_____

I authorize the following information to be disclosed:

▢All information related to my treatment
▢Only to confirm my attendance
▢Only to verify the duration of my treatment

▢Only the following limited details (please clearly specify what information you want disclosed)
_____
_____

II. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

This authorization ends:

If none of the below are checked, this authorization ends 2 years from the date signed
On (date) ____/_____/_____
When the following event occurs: _____

III. Client Signature

I, the client, have read the preceding information and understand my rights as a client

_____
Print Name of Client

_____ _____
Client's Signature Date

If the client is a minor or unable to sign please complete the following:

Client is a minor: _____ years of age

Client is unable to sign because: _____

I, the client's Parent, Legal Guardian, or Authorized Representative, have read the preceding information and understand the rights of the client and as the client's responsible party:

_____ _____
Print Name of Parent, Legal Guardian, or Authorized Representative Date

_____ _____
Signature of Parent, Legal Guardian, or Authorized Representative Date

Authority of representative to sign on behalf of the patient (check applicable):
▢Parent ▢Legal Guardian ▢Court Order ▢Other: _____

IV. Additional Consent for Certain Conditions

Your protected health information may contain information about **physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, or abortion**. Separate consent must be given before this information can be released. (Check if you do or do not consent to this additional authorization)
▢I consent to have the above information released.
▢I do not consent to have the above information released.

_____ _____
Print Name of Client or Authorized Representative Date

_____ _____
Signature of Client or Authorized Representative Date