HIPPA authorization for use or disclosure of health information FROM:

Salado Creek Mental Health, PLLC
14100 San Pedro Ave., Suite 320
Phone: (210) 450-3008 Fax: (210) 512-9583
This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: _____

Date of Birth: _____ Last 4 of SSN: _____

My Authorization: I authorize Salado Creek Mental Health PLLC to use or disclose the following health information. Please initial next to your selection

_____ All of my health information since I have become a patient of this practice
_____My health information covering the period from (date)_____ to_____
_____ My health information relating the following treatment or condition_____
_____
Other _____
_____

The above party may disclose this health information to the following recipient:

Name (or title) and organization: _____

Address: _____
_____

City: _____
_____

State: _____ *Zip*_____

*Phone:*_____*Fax:*_____

_____

The purpose of this authorization is (please initial all that apply):
_____ At my request
_____ At the request of my medical provider
_____ At the request of my parole/probation officer
_____ Collaboration of care with another provider
_____ My insurance requesting records
_____ Continuation of care - hospitalization

This authorization ends (please initial all that apply):
_____ On a specific date (**please indicate specific date)**_____
_____ On written notice from me
_____ Upon my death
_____ Upon departure from the practice
_____Specific Date Authorization Ends

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.

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

_____ Patient is a minor_____years of age
_____ Patient is unable to sign because:
Printed Name of Authorized Representative_____

Authority of representative to sign on behalf of the patient:

_____Parent
_____Legal Guardian
_____Court Order
_____Other_____

III. Additional Consent for Certain Conditions

This medical record may contain information about **physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment**. Separate consent must be given before this information can be released.

_____ I consent to have the above information released.

_____ I do not consent to have the above information released.

IV. Additional Consent for HIV/AIDS This medical record may contain information concerning **HIV testing and/or AIDS diagnosis or treatment**. Separate consent must be given to have this information released.

_____ I consent to have the above information released.

_____ I do not consent to have the above information released.

_____
Print Name

_____
Signature

Date