HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

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 the following using or disclosing party:

_____

to use or disclose the following health information. Please initial next to your selection

_____ All of my health information
_____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:

Salado Creek Mental Health, PLLC

14100 San Pedro Ave., Suite 320

Phone: (210) 450-3008 Fax: (210) 512-9583

The purpose of this authorization is (check all that apply):

_____At my request
_____Other_____

This authorization ends: On_____or <u>One year from this form date</u> OR

When the following event occurs_____

_____

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 if requested. 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