Acceptance & Healing LLC

AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

I,_____, hereby voluntarily authorize the disclosure of information from my health records by Acceptance and Healing, LLC.

The information is to be disclosed by:	**And is to be provided to:**
_____	_____
Name of Person/ Organization/ Facility	Name of Person/ Organization/ Facility
_____	_____
Address	Relationship
_____	_____
City/ State	Address
	_____
	City/State

For the Purpose of:
(Please initial next to appropriate box)

_ Coordination of Care
_ Personal Use
_ Other (*Specify*):
_____ Legal Purposes
_____ Insurance
_____ Administrative
_____ School

The information to be disclosed from my health record:
(Please initial next to appropriate box)

_ Only Information related to (*specify*) :_____
_ Only the period of event from:_____ to: _____
_ Other (*specify*): _____
_ Entire record

Unless otherwise revoked, this authorization will expire on the following date or event_____.
If a date or event is not specified, this authorization will expire **one year** from my date of signature below.

This authorization is voluntary. I understand that I can refuse to sign this authorization and Acceptance and Healing, LLC will not condition my treatment, payment, enrollment, or eligibility for benefits on the signing of this authorization except as allowed under federal privacy laws for (1) research related treatment, or (2) health care provided solely for disclosure to a third party, or 3) health plan initial enrollment/ eligibility determination, underwriting, or risk rating determination.

I understand that I may revoke this authorization at any time by notifying Acceptance and Healing, LLC, in writing, of my revocation. I understand that the revocation will not apply to any information that was already released in reliance on this authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule.

I hereby release Acceptance and Healing, LLC from all liability and all claims of any nature whatsoever pertaining to the disclosure of information, or of any professional opinions, findings, or recommendations as contained in the records released to or by Acceptance and Healing, LLC.

Patient Name (printed)	Clinical Psychologist Signature
Patient Signature	
Date	Date