

Integrative Empowerment Group, PLLC

Authorization for Use and Disclosure of Protected Health Information

I hereby authorize Integrative Empowerment Group, PLLC to use and/or disclose my protected health information as described below to

(name and address of recipient) _____

for the following purposes (client initials next to all that apply):

Coordination of Care Involvement of Support Person in Therapy
 Continuity of Care Other (specify): _____

I understand that:

1. **THIS AUTHORIZATION IS VOLUNTARY AND I MAY REFUSE TO SIGN THIS AUTHORIZATION WITHOUT AFFECTING MY HEALTH CARE OR THE PAYMENT FOR MY HEALTH CARE**
2. I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state and federal law. See 45 CFR § 164.524).
3. I may revoke this authorization at any time by notifying Integrative Empowerment Group, PLLC in writing as set forth in the Notice of Privacy Practices. However, it will not affect any actions taken before the revocation was received or actions taken in reliance thereon, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer with the right to contest a claim under the policy.
4. Integrative Empowerment Group, PLLC agrees to maintain the confidentiality of my protected health information; however, if the person or organization authorized to receive the information is not a health plan, health care clearinghouse or health care provider, federal law (HIPAA) requires me to be advised that information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPAA rules.

Type of Information to Be Disclosed (client initial):

<input type="checkbox"/> Assessment	<input type="checkbox"/> Testing Information	Other: _____
<input type="checkbox"/> Diagnosis	<input type="checkbox"/> Continuing Care Plan	_____
<input type="checkbox"/> Psychological Evaluation	<input type="checkbox"/> Progress in Treatment	_____
<input type="checkbox"/> Psychosocial Evaluation	<input type="checkbox"/> History	_____
<input type="checkbox"/> Treatment Plan or Summary	<input type="checkbox"/> Billing Records	_____
<input type="checkbox"/> Current Treatment Update		
<input type="checkbox"/> Participation in Treatment		

In addition, I authorize the release of the following information as a part of my clinical record (initial if applicable):

HIV/AIDS infection Drug/Alcohol abuse Genetic Testing

Expiration:

This authorization will expire 180 days from the date of signing or (insert date) _____.

Client Name

Legal Name

Signature of Client or Legal Representative

Date

Relationship to Client (if applicable)

- Parent or guardian of unemancipated minor
 Court appointed guardian
 Executor or administrator of decedent's estate
 Power of Attorney

Printed Name of Client's Representative (if applicable)

Signature of Witness

Date