## 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
_____ Continuity of Care
_____ Involvement of Support Person in Therapy
_____ 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):**

_____ Assessment
_____ Diagnosis
_____ Psychological Evaluation
_____ Psychosocial Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Participation in Treatment
_____ Testing Information
_____ Continuing Care Plan
_____ Progress in Treatment
_____ History
_____ Billing Records
Other: _____
_____
_____

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**

_____
**Printed Name of Client's Representative (*if applicable*)**

**Relationship to Client (*if applicable*)**
☐ Parent or guardian of unemancipated minor
☐ Court appointed guardian
☐ Executor or administrator of decedent's estate
☐ Power of Attorney

_____
**Signature of Witness**

_____
**Date**