AUTHORIZATION FORM (HIPAA)

Authorization for Disclosure of Protected Health Information

Information Exchange Between:

(Name, Org., Address, Phone)

Family Service Society, Inc.
280 Princeton Avenue Ext.
Corning, New York 14830
(607) 962-3148

Re: Patient/Client Name:
Date of Birth:

Purpose or Need for Disclosure:

Extent or nature of information to be disclosed:

( )	Screening/Admission Note	( )	Academic Progress Reports
( )	Psychiatric Assessment	( )	Teaching Observations
( )	Psychological Assessment	( )	Most recent C.O.H. Report
( )	Social Assessment	( )	Other _____
( )	Vocational Assessment	( )	_____
( )	Physical Assessment		_____
( )	Comprehensive Treatment Plan		_____
( )	Discharge Summary		_____

I hereby authorize the periodic release of the above information to the person/organization/facility/program identified above as often as necessary to plan for/provide care and treatment. I understand that the information to be released is confidential and protected from disclosure.

I specifically authorize the disclosure by the healthcare practitioner of the following types of protected health information by placing my initials where appropriate below, my initials serving as my signature release for each type of specially protected health information:

_____Psychotherapy Notes (as defined by HIPAA)
_____Confidential HIV Related Information
_____Alcohol/Substance Abuse Treatment Information

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Practitioner at the address above. I understand that a revocation is not effective to the extent that the Practitioner has relied on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by HIPAA or any other federal or state law, provided

My consent to release information to the person/organization/facility/program identified above, will expire when I am no longer receiving services from such person/organization/facility/program, or one year from this date, whichever occurs first.

The Practitioner will not condition my treatment on whether I provide an authorization for disclosure except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

_____ _____

Signature of Patient, or Parent of Minor Patient, or Personal Representative of Patient

Date

_____

Print Name of Patient, Parent of Minor Patient or Personal Representative of Patient (If a Personal Representative, also state relationship to patient.)

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