# AUTHORIZATION FORM (HIPAA)

Authorization for Disclosure of Protected Health Information

Name of Patient:_____

1. I authorize the healthcare practitioner: *Penny Siegmann-Beiner, LCSW-R* (the 'Practitioner") and/or the administrative and clinical staff of the Practitioner to disclose my (or my child's or my ward's) protected health information, as specified below, to:

a) Insurer _____ b) PCP_____

c) Psychiatrist/Nurse Practitioner/PA_____

d) Other _____ e) Other_____

2. I am hereby authorizing the disclosure of the following protected health information:

***Mental Health Treatment – including assessment, biopsychosocial history, diagnosis, symptomology, medication, dates of service, type of service, progress notes, concomitant issues (including drug and alcohol treatment, treatment related to HIV), etc.***

3. This protected health information is being used or disclosed for the following purposes:

***Case Coordination, Case Planning, and Treatment***

4. 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.

5. 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 however, that Confidential HIV Related Information and Alcohol/Substance Abuse Treatment Information may not re-disclosed without my authorization unless permission to re-disclose such information is granted by federal or state law.

6. 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.)

# Patient Request for Confidential Communications

We would like to identify the methods of communication that you prefer (e.g., phone, text, email). Please remember electronic communications such as voicemails, texts or emails are unencrypted and may be neither secure nor confidential.

If there is a significant issue, please DO NOT use email or text; rather, please leave a detailed voicemail message, and we will get back to you as soon as possible. Of course, if it is an emergency, please call 911. We place a high priority on getting back to our clients in a timely fashion. Therefore, if you do not hear back from us in at least 24 hours, then we probably didn't get the message. Unfortunately, phone systems periodically have problems, so please keep that in mind and kindly call again.

I wish to be contacted as follows **(Please check all that apply)**:

*NOTE: During telehealth, we will likely be using your cell # and/or email address.)*

□ At my home number: _____
- □ You can leave messages with detailed information
- □ Leave message with call-back number only

□ At my cell phone number: _____
- □ You can send texts with detailed information
- □ You can text regarding scheduling only
- □ You can leave message with call-back number only
- □ Send texts only re: _____

□ In writing at:
- □ My home address:_____
- □ My email address:_____

□ Instead of paper copies, please send correspondence, bills and reports to my email address:

_____ _____

Signature of Patient (or Parent of Minor) Date

_____

Print Name