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) MD/PA/NP____ _____

c) Other _____ d) Other _____

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

Mental Health Treatment – including assessment, biopsychosocial history, diagnosis, symptomology, 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. This authorization shall be in force and effect until one (1) year after the date below at which time this authorization to disclose protected health information shall expire.

5. 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.

6. 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.

7. 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.)

1. HIV is the Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts, including HIV test results. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights. Although I am authorizing this release of HIV-related to the recipient, the recipient is prohibited from re-disclosing such information without my authorization unless specifically permitted to do so under federal or state law.

2. Although I am authorizing this release of Alcohol/Substance Abuse treatment information to the recipient, the recipient is prohibited from re-disclosing such information without my authorization unless specifically permitted to do so under federal or state law.