Modern Wellness Psychotherapy & Healing
333 North Dobson Road, Suite 5, Chandler, AZ 85224 | 480-280-8888

HIPAA AUTHORIZATION FORM
Release of Information

Patient Name:_____

Date of Birth:_____

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The following individual(s) or organization(s) are authorized to make the disclosure:

3. The following individual(s) or organization(s) are authorized to receive the disclosed information:

4. The type of information to be used or disclosed is as follows:

_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Medication Management Information
_____ Presence/Participation in Treatment
_____ Nursing/Medical Information
_____ Educational Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Demographic Information
_____ Psychotherapy Notes* (*cannot be combined with any other disclosure)
_____ Other (please describe):

5. The information authorized to be released may be transmitted via regular U.S. mail, facsimile and/or electronically.

6. I understand that the information in my health record may include information relating to communicable disease, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

7. This information may be disclosed to and used by Modern Wellness Psychotherapy & Healing, 333 North Dobson Road, Ste. 5, Chandler, AZ 85224 for the purpose of assessment and treatment planning, to share information relevant to treatment when and where appropriate and to coordinate treatment services.

8. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire two (2) years from the date below.

9. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the party to whom this authorization is being provided. A photocopy of this release is as effective as the original.

10. Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

11. I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

_____ _____

Signature of patient (or Legal Representative if a minor) Date

If signed by Legal Representation, Relationship to Patient	Signature of Witness