

The Counseling Center

At Davidson United Methodist Church

Authorization for Use and Disclosure of Protected Health Information

I hereby authorize The Counseling Center at Davidson United Methodist Church to use and/or disclose my protected health information as described below to:

(name and address of recipient) _____

for the following purposes: (describe each purpose of use/disclosure - If disclosing different types of information below for different purposes, the authorization must specify the purpose for which each type of information is being disclosed.)

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 The Counseling Center at Davidson United Methodist Church 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) The Counseling Center at Davidson United Methodist Church 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

- | | | |
|--|---|--------------------------------------|
| <input type="checkbox"/> Entire Medical Record | <input type="checkbox"/> Medical Records for Continuity of Care | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Billing Statements | <input type="checkbox"/> Therapy Phone Contact | |
| <input type="checkbox"/> Consultation | <input type="checkbox"/> Assessment and Treatment Plan | _____ |
| <input type="checkbox"/> Process Notes | <input type="checkbox"/> Psycho-Social Evaluation | _____ |
| | <input type="checkbox"/> Termination Status | _____ |

In addition, I authorize that this will include health information relating to (check if applicable):

- HIV/AIDS infection Drug/Alcohol abuse

Expiration:

This authorization will be in effect until revoked in writing or (insert date) _____.

Patient Name: _____ Patient ID #: _____

Signature of Patient or Legal Representative

Date

Printed Name of Patient's Representative (if applicable)

Relationship to Patient (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