Modern
RELATIONSHIPS
Real-life resources & support

RELEASE OF INFORMATION - HIPAA AUTHORIZATION FORM

This form is the Release of Information (ROI) -- HIPAA Privacy Authorization Form, Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164).

This ROI is focused on emergency contacts and/or billing issues.

Client Name:

Date of Birth: / /

1. AUTHORIZATION: I authorize the selected individual, listed below, and **Carol Missel, LMHC,** to exchange, use and disclose the protected healthcare information described below. This authorized individual should be considered my emergency contact.

Contact Name:

Relationship to Contact:

Phone Numbers: mobile: home:

Street Address:

City, State, Zip: city:

state: zip:

RELEASE OF INFORMATION (continued)

2. CONTENT: The person listed below may be contacted regarding the following:

☐ An emergency if my safety and well-being is at risk

☐ Coordination of my medical care.

3. EFFECTIVE PERIOD: This authorization for release of information covers the period of healthcare from:

☐ All past, present, and future dates (preferred selection)

☐ This specific time range:_____ ––-_____

4. EXTENT OF AUTHORIZATION: Please indicate the appropriate selection(s) below.

☐ I authorize the release of my complete health record *(preferred selection)*

☐ … with the exception of information on communicable diseases (including HIV and AIDS).

☐ ... with the exception of information about the particular subject matter below:

_____

_____

RELEASE OF INFORMATION (continued)

5. I UNDERSTAND: This medical information may be used by the person I authorize to receive this information for medical treatment concerning client safety, billing or claims payment or health insurance coverage.

☐ By checking I state that I understand and agree to the above statement.

6. I UNDERSTAND: I have the right to revoke this authorization, in writing, at any time. I understand that said revocation is not eective to the extent that any person or entity has already acted in reliance 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.

☐ By checking I state that I understand and agree to the above statement.

7. I UNDERSTAND: understand that information used or disclosed, pursuant to this authorization, may be disclosed by the recipient and may no longer be protected by federal or state law.

☐ By checking I state that I understand and agree to the above statement.

By signing my name below, I are agreeing to this document.

Client Signature: _____

Date Signed: _____