Authorization for Disclosure of Protected Health Information

Provider: Harry Neff, M.Ed., LMHC, 509-939-9903

TYPE OF INFORMATION TO BE DISCLOSED:

I hereby authorize Harry Neff, M.Ed., LMHC, to disclose and/or receive the following protected health information:

- ☐ General Assessment Information
- ☐ General Assessment Information Specific to_____

- ☐ Other_____

PURPOSE OF DISCLOSURE/ EXCHANGE OF INFORMAT ION:

- ☐ At client's request
- ☐ Coordinate treatment
- ☐ Other _____

RECIPIENT OF PROTECTED HEALTH INFORMATION:

_____

Addressee(s) Institutional Class, Group or Other Affiliation

_____

Business phone Address City State/Zip

RELEASE REQUIRING SPECIFIC CONSENT:

I am aware that my records may contain healthcare information relating to testing, diagnosis or treatment for HIV/AIDS, for any other STD, for chemical dependency, and/or mental health. I specifically authorize **Harry Neff M.Ed., LMHC**, to disclose any and all such information, if not excluded by initialing below:

I intend to exclude from this Authorization healthcare information relating to testing, diagnosis or treatment for the following:

_____ Chemical Dependency; _____ Mental Health; _____ HIV/AIDS; _____ Sexually Transmitted Diseases

CONVEYANCE OF INFORMATION: _____ Telephone _____ Fax/Electronic Data Transfer _____ Mail

REVOCATION/RE-DISCLOSURE

I understand that I may revoke this authorization at any time by giving my health care clinician a written and signed statement of revocation, and that such a revocation will not be effective to the extent that substantial action may have already been taken in reliance on the authorization, including provision of health care services requiring subsequent disclosure to effect payment. I also understand that unauthorized re-disclosure of my health information by the recipient is a potential risk. If re-disclosed, privacy laws may no longer protect the information.

DURATION:

If not previously revoked, this authorization will expire (must specify a date, event or condition):

_____

CONDITIONS:

I understand that I have the right to refuse to sign this authorization; however, I also understand that refusing to do so may condition the treatment by **Harry Neff, M. Ed, LMHC.**

SIGNATURE:

This authorization covers protected healthcare information pertaining to the below-signed client and is effective from the date of the signature below.

_____ _____

Name of client (printed) Signature and Date