SOUL-AFFIRMING COUNSELING Medical Records

Patient Authorization Disclosure for Protected Health Information

l. Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Il. I hereby authorize Soul-Affirming Counseling to: (select one)  Disclose my information to: \_\_\_\_\_Obtain and use my information from:  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ST\_\_\_\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_  (**we only mail/secure email to physician offices and hospitals**) Telephone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Release the record to the patient indicated above in section I. |
| Ill. Specific description of the health information to be disclosed (include dates of service, type of service, etc.)  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  This health information is disclosed for the following purpose (if Authorization requested by the patient put "At the request of the individual” |
| IV. By providing this Authorization, I understand as follows:  A. I understand that this health information may include information regarding drugs, alcohol, and test  results if needed.  B. I understand that this Authorization is voluntary.  C. I understand that the health information to be released may be subject to re-disclosure by the recipient of the health information and no longer protected by the federal Privacy Right.  I understand that I may revoke this Authorization at any time by notifying Soul-Affirming Counseling in writing, but if I do, it will not have any effect on uses or disclosures prior to the receipt of the revocation.   1. I understand that, upon request, I may receive a copy of this Authorization form after I sign it. 2. I understand that this Authorization will expire on\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_ (MM/DD/YR). If left blank, expiration date will be two years from date by signature.   Patient or Patient's Representative's Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relationship to Patient (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ***SOUL-AFFRMING COUNSELING, LLC***  ***318 N. College St. Suite G. Auburn, AL 36830***  ***Phone: 334-539-8051***  ***Fax: 334-539-8051*** |