AUTHORIZATION TO DISCLOSE OF PATIENT HEALTH INFORMATION

Patient Name: _____

Address: _____

Date of Birth: _____ Date of Request: _____

As required by HIPAA Privacy Regulations, protected health information may not be used or disclosed to a third party without patient authorization.

I hereby authorize South Shore Mental Health Counseling Services P.C. and its associates to disclose my Protected Health Information to the following person(s), health care provider(s), or business associate indicated below:

Medical Doctor:_____

Psychiatrist:_____

Other:_____

Patient Health Information authorized to be disclosed: *Any and all information that may enhance my course of treatment at South Shore Mental Health Counseling Services.*

For the specific use or purpose of: *Enhancing my course of treatment at South Shore Mental Health Counseling Services.*

Effective dates for this authorization: _____/_____/_____ through _____/_____/_____. This authorization will expire at the end of the above period.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond your control.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of the Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

_____ _____

Signature or Patient or Patient's Authorized Representative *Date*