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Individual Patient Authorization

This form is to confirm authorization to use or disclose protected health information for a special purpose.

If this authorization is for psychotherapy notes, it may not authorize the use or disclosure of any other type of protected health information.

I, Name: _____

Address: _____

Telephone: (_____) _____

Give my authorization voluntarily to use or disclose my protected health information / psychotherapy notes

Type of protected health information to be used or disclosed: _____

Persons/ Organizations who may use or to whom this information may be disclosed: _____

Purpose for use or disclosure of protected health information: _____

This information will end on date on or in the event of: _____

Changing Your Mind About Authorization
I understand that I may revoke this authorization at any time by giving written notice to Alison Young, MFT. However, I understand that I may not revoke this authorization for any actions taken before receipt of my written notice to revoke this authorization. In addition, I understand that if I am giving this authorization as a condition of obtaining insurance coverage, and I revoke this authorization, the insurance company has a right to contest my claims under the insurance policy.

Signing This Authorization Is Not a Condition of Treatment
I understand that under most circumstances a healthcare provider may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this authorization. However, I understand that signing an authorization that permits the use or disclosure of my Protected Health Information for research purposes may be a condition of my treatment if I am undergoing a research-related treatment. Also, I may be required to sign an authorization if my treatment is provided solely for the purpose of creating Protected Health Information for disclosure to a third party. And, under some circumstances, a health plan may condition my enrollment in a health plan or my eligibility for benefits on my providing an authorization permitting the health plan to make enrollment and eligibility determinations.

Possibility of Redisclosure
I understand that information disclosed under this authorization may be redisclosed by the recipient. Federal privacy rules may not protect the privacy of my health information once the recipient rediscloses my health information.

Patient Signature
I have read, thought about the content of this authorization and agree with all the statements made in this authorization. I understand that by signing this form, I am confirming my authorization of use or disclosure of the Protected Health Information described in this form with the people / organizations named in this form.

Signature:_____ **Date:**_____