Pamela H. Gates MA, LPC-S, LCDC, ADCIII

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

PATIENT NAME: _____

ADDRESS: _____

DATE OF BIRTH: _____ DATE OF REQUEST _____

As required by the Privacy Regulations, this practice may not use or disclose your protected health information except as provided in out Notice of Privacy Practices without your authorization.

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s) or entity(s).

_____

Patient Health information authorized to be disclosed:

_____

_____

_____

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

I understand that I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this our previous reliance on the uses or disclosure pursuant to this authorization.
2. Inspect a copy of Patient Health Information being used or disclosed under federal law.
3. Refuse to sign this authorization.
4. Receive a copy of this authorization.
5. Restrict what is disclosed in this authorization.

I also understand that if I do not sign this document, it will not condition my treatment whether or not I provide authorization to use or disclose protected health information.

_____ _____

Signature of Patient or Authorized Representative Date

_____ _____

Pamela H. Gates Date