

HIPAA COMPLIANT AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient's Name: _____ DOB: _____ SSN: _____

I authorize the use or disclosure of the above named individual's health information as described below:

The following individual or organization is authorized to make the disclosure:

Name: CHILD'S PLAY THERAPY CENTER
Address: 3057 LORNA ROAD SUITE 220 BIRMINGHAM, ALABAMA 35216

The type of information to be disclosed is my entire medical record, prescription history, medications prescribed, itemized statements, and any other protected health information concerning me to _____ (The Company), or any of its associates. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Child'sPlay Therapy Center, or any of its associates, may plan appropriate services.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to Child'sPlay Therapy Center. I understand that a revocation is not effective to the extent that any of my providers have already relied on this Authorization to disclose information about me or to the extent that Child'sPlay Therapy Center has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that my providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, Child'sPlay Therapy Center may not be able to process my claim or may not be able to provide appropriate treatment. I understand that any authorized representative or I will receive a copy of this authorization upon request.

Signature of Patient or Personal Representative Date

Description of Personal Representative's Authority or Relationship to Patient