AUTHORIZATION FOR USE & DISCLOSURE OF HEALTH INFORMATION – *Peter Binnings LCSW*

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide *all* information requested may invalidate this Authorization. Your rights regarding this authorization are included on page two of this authorization.

DISCLOSURE OF HEALTH INFORMATION

I hereby authorize:
- ❑ An exchange of information between Peter Binnings LCSW and the below party ***-OR***
- ❑ Only for the below party to release information to Peter Binnings LCSW ***-OR***
- ❑ Only for Peter Binnings LCSW to release information to the below party

_____.

Party (person or program name), address (street, city, state, zip code) *(add Phone/Fax if needed)*

_____.

Peter Binnings LCSW 500 Chestnut St, Suite 175A. Santa Cruz, CA 95060. Phone: 510-761-6706 email: peter@peterbinnings.com

the following information *(check only one in each column):*

Category of Information
- ❑ Mental Health Records
- ❑ Family History
- ❑ Medical records and medical treatment.

Type of Information
- ❑ Only a Written Summary of Treatment – ***OR***
- ❑ Only the following records or types of health information:

_____

- ❑ Any verbal or written information, not including psychotherapy notes
  ** *note that any request for psychotherapy notes must be made on a separate release form.*

PURPOSE

Purpose of requested use or disclosure: ❑ to coordinate care between providers — ***AND/OR*** ❑ other:

_____

EXPIRATION

This Authorization expires:

- ❑ one year after the client terminates treatment with Peter Binnings LCSW ***OR***
- ❑ on the following date or event: _____

Agency Use Only:

❑ **AUTHORIZATION REVOKED!** If authorized representative later revokes consent, enter effective date of revocation: _____

SIGNATURE

Print Client Name: _____ Client Date of Birth: _____

Authorized Representative Signature:_____ Date Signed: _____

State legal relationship of Authorized Representative to the client: _____
Witness signature *(preferred, not required)*: _____

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YOUR RIGHTS

You may refuse to sign this Authorization. Your refusal will not affect your ability to obtain treatment or payment or eligibility for benefits.[1]

You may inspect or obtain a copy of the health information that you are being asked to allow the use or disclosure of.

You may revoke this authorization at any time, but you must do so in writing and submit it to program that is releasing the information.

Your revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization.

You have a right to receive a copy of this authorization.[2]

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA).

[1] If any of the HIPAA recognized exceptions to this statement applies, then this statement must be changed to describe the consequences to the individual of a refusal to sign the authorization when that covered entity can condition treatment, health plan enrollment, or benefit eligibility on the failure to obtain such authorization. A covered entity is permitted to condition treatment, health plan enrollment or benefit eligibility on the provision of an authorization as follows: (i) to conduct research-related treatment, (ii) to obtain information in connection with a health plan's eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations, or (iii) to create health information to provide to a third party or for disclosure of the health information to such third party. Under no circumstances, however, may an individual be required to authorize the disclosure of psychotherapy notes.

[2] Under HIPAA, the individual must be provided with a copy of the authorization when it has been requested by a covered entity for its own uses and disclosures *(see 45 C.F.R. Section 164.508(d)(1), (e)(2)).*