Authorization for Use and Disclosure of Protected Health Information

Second City Counseling Services – the practice of Amanda L. Hess, LMHC
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Phone: (808) 384-8279 Fax: (808) 676-5065

I authorize Second City Counseling Services to release and obtain the protected health information of:

Patient Name:_____ DOB:_____ SSN: _____

Address:_____ Phone:_____

To/From (the Name of Person/Agency):_____ Phone:_____

Address:_____

Information to be disclosed:	Purpose for Use/Disclosure:
□ *Entire Record*	□ *Continuity of care*
□ Discharge Summary	□ Client's request
□ ER report	□ Insurance purposes
□ X-Ray/Imaging Reports	□ Legal purposes
□ Consults	□ Other:
□ History and Physical	
□ *Operative Reports*	
□ Laboratory Results	
□ Other:	

I agree to the release of the following information even if it should contain in my medical record: Acquired Immune Deficiency Syndrome (AIDS) or HIV, substance abuse treatment, or behavioral and mental health services.

Unless otherwise revoked, this authorization will expire on the following date or event: _____. If a date or event is not specified, this authorization will expire one year from my date of signature below.

This authorization is voluntary. I understand that I can refuse to sign this authorization and Second City Counseling Services (SCCS) will not condition my treatment, payment, enrollment or eligibility for benefits on the signing of this authorization except as allowed under federal privacy laws for: (i) research-related treatment; or (ii) healthcare provided solely for disclosure to a third party; or (iii) health plan initial enrollment/eligibility determinations, underwriting or risk-rating determinations.

I understand that I may revoke this authorization at any time by notifying SCCS, in writing, of my revocation. I understand that the revocation will not apply to any information that already has been released in reliance on this authorization.

I understand that the health information released under this authorization may be re-disclosed by the recipient and may no longer be protected under federal privacy regulations.

I hereby release Second City Counseling Services, the practice of Amanda L. Hess, LMHC, from all liability and all claims of any nature whatsoever pertaining to the disclosure of information, or of any professional opinions, findings, or recommendations as contained in the records released to or by Second City Counseling Services, the practice of Amanda L. Hess, LMHC.

Signature: _____ Therapist Signature: _____

Print Name, Date: _____ Print Name, Date: _____

Relationship to Patient: _____