NEW FOUNDATION INNER HEALTH

AUTHORIZATION TO RECEIVE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name:____Date of birth:____/____/_________

I understand that this authorization is voluntary. I understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information and/or state laws. Refusal to sign the authorization will not adversely affect my ability to receive healthcare services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider the information may no longer be protected by state or federal privacy regulations. I understand I may request a copy of this document.

I authorize R.L. Perez, PC doing business as New Foundation Inner Health to RECEIVE and DISCLOSE the following protected health information to improve assessment and treatment planning, share information relevant to my treatment and when appropriate, coordinate treatment services with the individual, clinic, or facility indicated within this authorization.

Please check appropriate box(es) that describe the protected health information to be received and disclosed.

Medical records   Billing Records   Laboratory Test Reports
Only events from______________to________________dates.   Other *(specify)*: ____

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this protected health information will be disclosed if I place my INITIALS in the applicable space next to the type of information:

(MUST Initial ONLY ONE below) psychotherapy notes are the notes your mental health professional takes documenting or analyzing the contents of conversation during a private, group, joint, or family counseling session.
(Initial)_______Mental Health Information (with psychotherapy notes)
(Initial)_______Mental Health Information (without psychotherapy notes)

(OPTIONAL) Initial all the apply below.
(Initial)_________Genetic testing information
(Initial)_________HIV/AIDS information
(Initial)_________Drug/Alcohol diagnosis, treatment, referral information

CHECK ALL THAT APPLY: Release Information To: Obtain Information From:
Name:____Relationship (doctor, parent, etc.)___________________Phone:_____________
Address:____Fax:______________________
City:____State:_______Zip code: ____________

If this authorization has not been revoked, it will terminate one year from the date signed, unless either a different expiration date or expiration event is initialed below.

(Initial ONLY ONE)
(Initial)______Expiration date: _______________ (enter date you want this authorization to expire)
(Initial)_________Expiration event: termination of care (i.e., when you stop seeing your provider)

I understand I can revoke this authorization in writing at any time. To revoke this authorization, I must complete a "Revocation of Authorization to Release and Disclose Protected Health Information" form and submit it to NFIH.

(Patients 14 years and OLDER please sign below)
By signing below, I acknowledge that I have read, understand, and agree with this "Authorization to Receive and Disclose Protected Health Information" as I have specified above.

Date:____/____/_________

____
Signature of Patient or Patient's Legal Representative

____
Printed name of Patient or Patient's Legal Representative

If signed by Patient's Legal Representative, description of personal representative's authority:
Parent ☐ Legal guardian ☐ Power of Attorney ☐ Other_______________________