New Strength Counseling LLC

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards and 42 CFR§ 2
The information released by this authorization is not authorized to be redisclosed to any additional parties without the consent of the client. See 42 CFR §2.32.

Print Name of Patient: ____DOB: __________________
Address:____

I. My Authorization

I authorize the following using or disclosing party:
New Strength Counseling LLC, Christina Anderson, MSW, LCSW, LCAC
7230 Arbuckle Commons, 183 Brownsburg, IN 46112

to use or disclose to and obtain from the following health information.
☐ - All of my health information
☐ - My health information relating to the following treatment or condition:________________________________
____
☐ - My health information covering the period from __________ (date) to __________ (date)
☐ - Other: ____

The above party may disclose this health information to the following recipient:
Name (or title) and organization ____
Address ____
City __________________ State __________________ Zip __________________
Phone __________________ Fax __________________ Email __________________

The purpose of this authorization is (check all that apply):
☐ - At my request
☐ - Other:
____

This authorization ends:
☐ - On (date)________________
☐ - When the following event occurs: ____

II. My Rights
*I have been given a copy of my rights and information regarding HIPAA Policy and Procedure and Privacy of my healthcare information.

Signature of Patient or Authorized Representative: ____________________________ Date: ______________Time: ________

III. Additional Consent for Certain Conditions
This medical record may contain information about physical or sexual abuse, alcohol use, drug abuse, abortion, or mental health treatment. Separate consent must be given before this information can be released.
☐ - I consent to have the above information released.
☐ - I do not consent to have the above information released.
☐ - I consent with the following clarification____

Signature of Patient or Authorized Representative: ____________________________ Date: ______________Time: ________

IV. Additional Consent for HIV/AIDS
This medical record may contain information concerning HIV testing and/or AIDS diagnosis or treatment. Separate consent must be given to have this information released.
☐ - I consent to have the above information released.
☐ - I do not consent to have the above information released.

Signature of Patient or Authorized Representative: ____________________________ Date: ______________Time: ________

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Signature of Witness____ Date: ________________Time: _________