HIPPA Privacy Authorization Form

Name: _____ **DOB:** _____ **Effective Date:** _____

Authorization to Use or Disclosure of information Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. **Authorization.** I authorize _____ to send and receive, use and disclose the protected information described below to individuals known as John Genardo, Licensed Clinical Mental Health Counselor (Individual seeking information). **Address: 395 Main St., Suite 1, Oneonta, NY 13820 Phone: 607-287-0058 Fax: 607-441-3023**
   Secure email: _____ . I authorize Genardo Mental Health Counseling P.C. to send and receive, use and disclose the protected information described below to individuals/group known as

   _____

2. **Effective Period.** This authorization for release of information covers all past, present, and future periods.

3. **Extent of Authorization.** I authorize the release of my complete information of:

   _____

   _____

   _____

4. **Use.** This information may be used by the people I authorize to receive this information for mental health treatment or consultation, billing or claims payment, or other purposes I may direct.

5. **Termination.** This authorization shall be in force and effect until an event described as One Year from this date _____ , at which time this authorization form expires.

6. **Revocation of Rights.** I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not in effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. **Benefits.** I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. **Disclosure.** I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____
Client's Signature **Date**

_____ _____
Client's Printed Name **Relationship to Client**

_____ _____
Clinician's Signature **Date**

_____ _____
Signature of Staff Person Using/Disclosing Information and Title **Date**