HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

LITTLE BIRD PSYCHOTHERAPY, P.S., INC

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

_____

Name of Patient Date of Birth

My Authorization

I _____ hereby authorize Tiffany Cannon-Keiser/Little Bird Psychotherapy to use, release, disclose or obtain 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_____ to_____

☐ - Other: _____

The purpose of this authorization is (check all that apply):

☐- At my request ☐ - Coordination of Care

☐ - Other: _____

This authorization will expire on

☐ - Date: _____ ☐ - One year from signature

TO: ☐	FROM: ☐
Organization/Entity	Little Bird Psychotherapy
Address:	1325 W. 1st Avenue, Suite 202
City/State/Zip:	Spokane, WA 99201
Phone/Fax:	509-844-2982/833-520-4835

TO: ☐ FROM: ☐

Organization/Entity: _____

Adress: _____

City/State/Zip: _____

Phone/Fax: _____ _____

Records to be released or obtained: ☐ Entire Record including ALL items listed below:

☐ Intake Evaluation	☐ Diagnostic Assessment	☐ Nutritional Documentation
☐Treatment Plans	☐ Administrative Records	☐ Psychiatric Documentation
☐ HIV/AIDS Records	☐ Discharge Summaries	☐ Substance Use Disorder Records
☐ Progress Notes	☐ Verbal Communication	☐ Medical Documentation/Labs

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My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

_____

Signature of Patient Date

If the patient is a minor or unable to sign, please complete the following:

☐ - Patient is a minor: _____ years of age

☐ - Patient is unable to sign because: _____

_____

Printed Name & Signature of Authorized Representative Date

Authority of representative to sign on behalf of the patient:

☐ - Parent ☐ - Legal Guardian ☐ - Court Order ☐ - Other: _____

Additional Consent for Certain Conditions

This medical record may contain information about physical or sexual abuse, substance use, 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.

_____

Signature of Patient or Authorized Representative Date

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: