(For Office Use Only)
Expires: __________

AUTHORIZATION OF USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION FORM

Part I: NOTICE OF IMPORTANT INFORMATION ABOUT YOUR RIGHTS RELATING TO THIS AUTHORIZATION OF USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION FORM.

Notice: Signing This Authorization Form Will Authorize The Use Or Disclosure Of Your Protected Health Information. Read The Following Information and Complete The Reverse Side Of This Form In Its Entirety Before You Sign This Authorization Form At The Designated Location Below.

By my signature on this Authorization Form at the designated location below, I acknowledge and agree that I have the opportunity to review the Notice of Privacy Practices of the Covered Entity that is the North Texas Therapy Innovations, P.C. and have read and understood the following statements about my rights relating to my authorization of the use or disclosure of my Protected Health Information as provided specified in this Authorization:

- My signature of this Authorization will permit North Texas Therapy Innovations, P.C. to use or disclose the Specified Protected Health Information to the Receiving Parties as provided on the reverse side of this Authorization Form for the purposes specified in this Authorization before expiration of this Authorization.
- The information that is used or disclosed pursuant to this Authorization may be redisclosed by the Receiving Parties. I have the right to seek assurances from the Receiving Parties that they will not redisclose the information to any other party without my further Authorization except as permitted without Authorization under Federal law.
- I have a right to receive a copy of this Authorization Form, as signed by me.
- I may see and copy the information described on this Authorization Form if I ask for it.
- A health care provider, health plan, or other covered entity may not condition my treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization except that: (i) a covered health care provider may condition the provision of research-related treatment on provision of an authorization for the use or disclosure of protected health information for such research under this section; (ii) a health plan may condition enrollment in the health plan or eligibility for benefits on provision of an authorization requested by the health plan prior to an individual's enrollment in the health plan, if: (a) the authorization sought is for the health plan's eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations; and (b) the authorization is not for a use or disclosure of psychotherapy notes within the meaning of 45 C.F.R § 164.501; and (iii) my health care provider or other covered entity may condition the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party on provision of an authorization for the disclosure of the protected health information to such third party. If a health care provider or health plan conditions requires that I provide this Authorization in accordance with any of the preceding exceptions, I understand that my failure to provide this Authorization may lead to my being denied the treatment, payment, enrollment or eligibility of benefits which is conditional upon my providing this Authorization.
- I understand that I do not have to sign this Authorization Form. If I refuse to sign this Authorization Form, however, the Disclosing Parties may not use or disclose my Protected Health Information other than those uses or disclosures described in the Notice of Privacy Practices as permitted without an authorization in accordance with Federal law.
- I may revoke this Authorization at any time prior to its expiration date by notifying the Disclosing Parties in writing, but the revocation will not have any affect on any uses or disclosures made before it received the revocation or any other uses or disclosures described in the Notice of Privacy Practices as permitted without an authorization in accordance with Federal law.

Part II: SIGNATURE OF PATIENT OR PATIENT'S PARENT, LEGAL GUARDIAN OR AUTHORIZED PERSONAL REPRESENTATIVE ("PERSONAL REPRESENTATIVE")

By my signature below, I authorize the use or disclosure of my individually identifiable protected health information as specified on the reverse side of this Authorization. I represent that this Authorization is voluntary, and that I am the patient or personal representative of the patient that is the subject of the protected health information identified in this form. (Both sides of this Authorization Form MUST be completed before signing.)

____ _______________
Signature of Patient or Personal Representative **Date**

____
Printed Name of Patient or *Personal Representative*

***Personal Representative ONLY MUST complete the following*:**

Personal Representative's Address:_______________________________
Personal Representative's Telephone:_______________________________
Relationship to Patient (Check One): Parent Legal Guardian Patient's Authorized Personal Representative (if checked complete *below)
***If Patient's Authorized Personal Representative, Describe Basis for Status of Patient's Authorized Representative (e.g. Power of Attorney) and Attach Relevant Documentation (e.g. Power of Attorney):** _______________________________
____

Part III. EXPIRATION OF AUTHORIZATION

This Authorization will expire (*Indicate date, or event relating to you personally or purpose of disclosure*):_______________________________
____

THIS FORM MAY NOT BE USED TO AUTHORIZE THE DISCLOSURE OF PSYCHOTHERAPY NOTES.

CONFIDENTIAL PROTECTED HEALTH INFORMATION: This document contains or requests "protected health information" within the meaning of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Federal and Texas law and District policy prohibit, and require utilization of appropriate safeguards against, wrongful use, access or disclosure of protected health information, other than as allowed by applicable Federal and state law and District policy. Wrongful access, use, or disclosure of this information may expose violators to civil and criminal liability under Federal and/or state law, discipline by the District, or both. Copyright 2003 to Cynthia Marcotte Stamer . Used with permission.

AUTHORIZATION OF USE/DISCLOSURE OF
PROTECTED HEALTH INFORMATION FORM

Part IV: AUTHORIZATION OF USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:	______________________	**Contact Telephone**	______________________
Patient Street Address	______________________	**ID Number:**	______________________
Patient City, State & Zip Code	______________________	**Social Sec. Number:**	______________________

Disclosing Parties: The name or other specific identification of the person(s), organizations, or class of persons that I authorize to use or disclose the specified protected health information described below are the following:

Receiving Parties: The name or other specific identification of the person(s), organizations, or class of persons that I authorize to receive the protected health information **described** below include the following:

Specified Protected Health Information: The Protected Health Information that I authorize to be used or disclosed (including date(s)) by this Authorization is (include **dates**):

Specific purpose of the disclosure is as follows:

I understand that the **Disclosing Party (North Texas Therapy Innovations, P.C.)** □ **will not** or □ **will receive** financial or in-kind compensation in exchange for using or disclosing the specified protected health information described above? If yes, describe:

I understand that the **Disclosing Party (North Texas Therapy Innovations, P.C.)** □ **will not** or □ **will use this information** for the following research purposes**.** If yes, describe:

CONFIDENTIAL PROTECTED HEALTH INFORMATION: This document contains or requests "protected health information" within the meaning of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Federal and Texas law and District policy prohibit, and require utilization of appropriate safeguards against, wrongful use, access or disclosure of protected health information, other than as allowed by applicable Federal and state law. Wrongful access, use, or disclosure of this information may expose violators to civil and criminal liability under Federal and/or state law, discipline by the District, or both. Copyright 2003 to Cynthia Marcotte Stamer . Used with permission.