LINDEMAN & ASSOCIATES Psychological Services

HIPAA Release of Information Authorization Form

I, _____hereby authorize mental health professionals and its affiliates, its employees and agents to release to health professionals and/or insurance companies my personal health information such as information relating to the diagnosis, treatment, claims, payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, and Member ID number) **except** the following information about me:

_____ **[DESCRIBE INFORMATION NOT TO BE DISCLOSED, IF ANY]** for the purpose of helping me to resolve claims and health benefit coverage issues. I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

This authorization is valid from the date of my signature below and shall expire the earlier of _____ **[INSERT DATE/EVENT UPON WHICH THIS AUTHORIZATION EXPIRES]** or the date my coverage ends with this mental health professional office.

I understand that I have a right to revoke this authorization by providing written notice to my mental health professional office. However, this authorization may not be revoked if its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits, enrollment, or payment for or coverage of services.

Client Name:_____

Client Signature: _____**Date:**_____

If applicable, Legal Representative of Client sign below

By signing this form, I represent that I am the legal representative of the client identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the client's behalf with respect to this authorization form.

Name of Legal Representative:_____

Signature of Legal Representative:_____**Date:** _____

Name of Witness:_____

Signature of Witness:_____**Date:**_____