Life is a Process...

Dr. Jan Holmes, LPC, PLLC

Better Life Counseling

HIPAA AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

I request and authorize Dr. Jan Holmes, LPC, PLLC, to release my health care information to:

Name: _____

Address: _____

City, State, Zip: _____

Reason for requesting records: _____

_____

This request and authorization applies to health care information relating to the following treatment, condition, or dates of treatment:

_____

Or _____ All health care information Or _____ Other: _____

THIS AUTHORIZATION EXPIRES ON _____ OR _____ DAYS AFTER THE DATE IT IS SIGNED; or WHEN THE FOLLOWING EVENT OCCURS: _____

_____

I may cancel this authorization to the extent allowed by law. If I do, I understand that the doctor or practice may have already released information about me after I gave permission. I know that canceling this authorization would not prohibit any release of information by the doctor or practice in reliance on my original authorization. There are two ways to cancel this agreement. I can;

- **_Sign and date the bottom of this form under the section labeled "Revocation of Authorization"; or**

- **_Write a letter to the doctor or practice. If I write a letter, it must say that I want to cancel my authorization to disclose my health care information. My letter must include the name or other specific identification of the person(s) that I no longer want to receive information. I (or my authorized representative) must sign and date the letter.**

Once my doctor gives out the information that I want released, I know that my doctor has no control over the information. The individual or organization that I authorized to receive the information might re-disclose it. Federal or state privacy laws may no longer protect the information.

_____

Signature of patient or patient's authorized representative Date

_____

Relationship or status if signed by parent, legal guardian, personal representative, etc.

REVOCATION OF AUTHORIZATION

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and health care operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____