

APPENDIX: HIPAA AUTHORIZATION FORM

HIPAA AUTHORIZATION TO RELEASE PROTECTED HEALTH Information in accordance with federal rules, 42 CFR part 2 (Confidentiality of Substance Use Disorder Patient Records) and 45 CFR part 164 (Health Insurance

Portability and Accountability Act of 1996), I authorize the release of information about me as indicated below. I understand information about

any of the following may be included in the release: behavioral health, sexuality and reproductive health, HIV/AIDS, sickle cell anemia,

communicable diseases, drug and alcohol use, and treatment for a substance use disorder.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby authorize My Healing Space Counseling PLLC (MHS) to release the following protected health information to the following individual(s) or entity for the stated purposes:

Name of Recipient(s): Address:

Phone:

Fax (PHI authorized to be sent via fax):

Relationship to Patient:

Information Authorized for Release:

Purposes of the Release Authorized: