AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Client Name (print clearly): _____ **DOB:** _____
Counselor Name: _____
Location: 4144 E. Amity Ave, Nampa, ID 83687 FAX: (208) 318-0218 PH: (208) 465-4985

I, the client as listed above, herby authorize Refuge Counseling Center LLC and its affiliates, including the provider listed above, to use and/or disclose my individually identifiable Protected Health Information ("PHI") in the manner described below.

I understand that the person or entity receiving my PHI, may re-disclose my PHI, and that it then may no longer be protected by federal privacy regulations. State law may or may not prohibit such redisclosure by the person or entity receiving my PHI. I voluntarily sign this authorization, and I understand that my health care will not be affected if I do not sign this form.

☐ **Obtain information from AND/OR** ☐ **Disclose information to:**

Name and Address:

_____

Phone: _____ Fax: _____

CATEGORY, PURPOSE, AND LIMIT OF PHI

Please indicate the category of PHI you wish to release:

☐ Treatment summary ☐ History/Intake ☐ Diagnosis

☐ Dates of treatment attendance ☐ Third party payment invoice (ex. name, date of service, fee)

☐ Superbill (ex. invoice info, diagnoses & procedure codes)

☐ Other (as specified): _____

Please indicate the purpose of authorizing this release:

☐ Evaluation/Assessment ☐ Coordinating treatment efforts

☐ Other (as specified): _____

I understand that this authorization extends to all or any part of the records/information designated above which may include treatment of mental health diagnoses. I understand that if I wish to limit the use and disclosure of my PHI, I would have indicated so as stated below, including specific information/dates.

List any limits of disclosure of PHI: _____

I understand that this authorization will expire on the following date or event: _____.
If no specific date or event is stated, this authorization will expire one (1) year from the date of this authorization. I understand that I have the right to receive a copy of this authorization. I also understand that I may revoke or modify this authorization at any time by notifying the above provider in writing. I understand that my revocation or modification of this authorization will not affect any actions taken by the provider mentioned above in reliance on this authorization before the provider mentioned receives my request for revocation or modification. I must sign my written request and send it to Refuge Counseling Center LLC at 4144 E. Amity Ave, Nampa, Idaho 83687.

Signed: _____ Date: _____
If not signed by the client, please indicate authority or relationship: _____

Note to Agency/Person receiving information: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42CFR Part 2.1) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical information is NOT sufficient for this purpose.