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INDIVIDUAL AUTHORIZATION FORM FOR RELEASE OF INFORMATION

Client Name: _____

Gateway to Wellness, LCSW, PLLC understands that information about your health is personal. I am committed to protecting the privacy of that information. Because of this commitment we must obtain your written authorization before we may disclose your protected heath information for the purposes described below. This form provides that authorization and helps us make sure you are properly informed of how this information will be used or disclosed. Please read the information below carefully before signing this form.

USE AND DISCLOSEURE COVERED BY THIS AUTHORIZATION

You or your personal representative should read the descriptions below before signing this form.

Who will disclose the information? Please name the person(s) or class of persons authorized to disclose the information:

_____

_____

_____

Who will use and/or receive the information? Please name the person(s) or class of persons authorized to use and/or receive the information:

_____

_____

What information will be used or disclosed? The descriptions should be in enough detail so that you (or any organization that will disclose information because of this authorization) can understand what information may be used or disclosed (for example “Overall Behavioral/Mental Health and /or Loss of Job Situation.”)

The following information:

_____

_____

_____

( ) Check and list if the following statement applies to this disclosure.

The following HIV-related information (which is any information indicating that you have had and HIV-related test or have HIV infection, HIV- related illness or AIDS, or any information which could indicate that you have been potentially exposed to HIV):

_____

What is the purpose of the use or disclosure? Please state the purpose of the use(s) or disclosure(s) of the information. The words” at the request of the individual” are a sufficient description.

_____

_____

_____

When will this authorization expire? Please state the date or event that will trigger the expiration of this authorization.

_____

SPECIFIC UNDERSTANDINGS

By signing this authorization form, you authorize the use or disclosure of your protected health insurance information as described above. This information may be redisclosed if the recipient(s) described on this form is not required by law to protect the privacy of the information, and such information is no longer protected by federal health information privacy regulations:

If you are authorizing the release of HIV-related information without your authorization unless permitted to do so under federal or state law. You also have a right to request a list of people who

may receive or use your HIV-related information without authorization. If you experience discrimination because of the release or disclosure of HIV-related information, you may contact the New York State Division of Human Rights at (212) 870-8624 or the New York City Commission of Human Rights at (212) 566-5493. These agencies are responsible for protecting your rights.

You have a right to refuse to sign this authorization. Your health care and your health care agencies will not be affected if you do not sign this form. You have a right to see and copy the information described on this authorization form. You also have a right to receive a copy of this form after you have signed it.

If you sign this authorization, you will have the right to revoke it at any time, except to the extent that Gateway to Wellness, LCSW, PLLC has already taken action based upon your authorization. To revoke this authorization, please complete a Request to Revoke Authorization Form and return it, signed and dated to: Gateway to Wellness, LCSW, PLLC.

I have read this form and all my questions about this form have been answered. By signing below, I acknowledge that I have read and accept all the above.

_____ _____
Signature of Client or Personal Representative Date

_____
Print Name of Client or Personal Representative

_____
Description of Personal Representatives Authority

CONTACT INFORMATION

The contact information of the client or personal representative who signed this form should be filed in below.

Address: **Telephone:**

_____ _____
_____ Daytime
_____ _____
Evening

E-Mail Address (optional): _____