AUTHORIZATION TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS (TPO)

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Patient Name_____

Federal regulations (HIPAA) allow me to use or disclose Protected Health Information (PHI) from your record in order to provide treatment to you, to obtain payment for the services I provide, and for other professional activities (known as "health care operations"). Nevertheless, I ask for your authorization in order to make this permission explicit. The Notice of Privacy Practices describes these disclosures in more detail. You have the right to review the Notice of Privacy Practices before signing this authorization. I reserve the right to revise the Notice of Privacy Practices at any time. If I do so, the revised Notice will be posted in the office. You may ask for a printed copy of my Notice at any time.

You may ask me to restrict the use and disclosure of certain information in your record that otherwise would be disclosed for treatment, payment, or health care operations; however, I do not have to agree to these restrictions. If I do agree to a restriction, that agreement is binding.

You may revoke this authorization at any time by giving written notification. Such revocation will not affect any action taken in reliance on the authorization prior to the revocation.

This authorization is voluntary; you may refuse to sign it. However, I am permitted to refuse to provide mental health care services if this authorization is not granted, or if the authorization is later revoked.

I hereby authorize the use of disclosure of my Protected Health Information as specified above.

Signature of Patient:_____ Date: _____
(for persons 12 and over)

Signature of Parent/Legal Guardian: _____ Date: _____
(for persons under18 years of age)

Signature of Witness: _____ Date: _____