Authorization to Use or Disclose Protected Health Information

I, ______________________________ , authorize the use or disclosure of my protected health information as described below:

1 My authorization applies to the specific information described:

____

2 I authorize the following person (or class of persons) to make the authorized use or disclosure of my protected health information and to receive information: Teresa Utley M.S. MFT Associate

3 I authorize the following persons (or class of persons) to receive and disclose my protected health information (List Doctor or facility):
Name(s): ______________________________
Address: ______________________________

4 I understand that, if my protected health information is disclosed to someone who is not required to comply with the Federal privacy protection regulations, then such information may be redisclosed and would no longer be protected.

5 I understand that I have a right to revoke this authorization at any time. My revocation must be in writing (by a letter including name, address, telephone number, and reason why revocation is requested). I am aware that my revocation is not effective to the extent that the person I have authorized to use or disclose my protected health information have acted in reliance on this authorization.

6 This authorization expires one year from date of issue or (condition)____.

7 I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from my therapist or my eligibility for benefits.

8 I understand that I have a right to inspect and copy my own protected health information to be used or disclosed in accordance with the requirements of the federal privacy protection regulations found under 45 C.F. R. 154.524.

9 I can request a copy of this authorization at any time.

10 I agree that a photocopy, facsimile or scanned (emailed) of this signed authorization form shall be considered as valid as an original signed copy.

I certify that I have had the opportunity to review this form.

Signature ______________________________ Date ______________

Print Name ______________________________

Personal representative: ______________________________

If Applicable: Parent Court ordered Power of Attorney Other

______________________________ : ______________________________ ______________

Teresa I. Utley, M.S. MFT Associate Date