PIER VIEW COUNSELING

HIPAA Release of information
AUTHORIZATION FORM

I, _____hereby authorize Dr._____ and its affiliates, its employees and agents (collectively _____), to release to **Lydia Lombardi Good, LCSW of Pier View Counseling** my personal health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of **coordinating your plan of care in therapy**.

Please release all *except* the following information about me:_____.

If no exceptions, please check N/A [ ].

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws. This authorization is valid from the date of me/my representative's signature below and shall expire **1 year from this date this authorization was signed** or the date my therapy is terminated with **Lydia Lombardi Good, LCSW**.

I understand that I have a right to revoke this authorization by providing written notice to my therapist, **Lydia Lombardi Good, LCSW**. However, this authorization may not be revoked if **Lydia Lombardi Good, LCSW** has taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization. I further understand that this is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

Name of Client _____

Signature of Client _____

Date _____

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form. Name of Legal Representative _____

Signature of Legal Representative _____

Date _____

Name of Witness _____

Signature of Witness _____