DKC Yoga, PLLC

Authorization for use and disclosure of protected health information

Client Name:_____ **DOB:** _____

The person named above hereby authorizes _____ **to**

❒ Disclose information to: ❒ Obtain* information from: ❒ Exchange* information with:

*I authorize the person or organization named below to disclose information to DKC Yoga, PLLC.

Name _____

Organization _____

Address _____

Telephone _____ Fax_____ Email _____

Information requested from other sources

- ❒ Lab results
- ❒ Medical information
- ❒ Records of hospitalizations
- ❒ Other: _____
- ❒ Current school records
- ❒ Psychiatric information
- ❒ Mental health information

Information to be disclosed by DKC Yoga, PLLC:

- ❒ All Records from date _____ to date _____ OR ❒ All Records
- ❒ Session Notes
- ❒ Intake summary, Progress summary, discharge summary
- ❒ Other (specify) _____

For the purpose of (specify) ❒ at the request of the client; OR ❒_____

Specific Authorizations

____ (Initial) DRUG & ALCOHOL: I understand that my records may contain information, diagnosis or treatment for drug or alcohol abuse. I give my specific authorization for records to be released (CFR 42, Part 2).

____ (Initial) STD/AIDS/HIV: I understand that my records contain information regarding testing, diagnosis, or treatment of STD/HIV/AIDS. I give my specific authorization for these records to be released. RCW 70.02.220.

REDISCLOSURE PROHIBITED: This information has been disclosed to you from records whose confidentiality is protected by state or federal law. These laws prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Information is requested in keeping with RCW 70.02.030 and HIPAA (Public Law No. 104-191*).*

I understand and agree that:

- *This authorization is voluntary*
- *I may* **revoke this authorization in writing at any time, unless the agency has already disclosed the information.**
- **Treatment, enrollment or eligibility for benefits is not conditioned on signing an authorization.**
- **Any authorization requiring your signature that results in information disclosed to a non-covered entity may be subject to redisclosure and no longer protected by law.**
- **This authorization expires 90 days after the end of treatment with DKC Yoga, LLC OR on _____ date.** *If the disclosure is to a financial institution or employer, the authorization expires 90 days after signing unless renewed by the patient.*

I, as the client or parent or guardian of the client, give my specific authorization for this information to be released.

_____ _____

Signature of Client/Legal Representative **Date**

_____

Legal Representative's authority to act for client