AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name (print): _____________________________________ Date of Birth: _______________________

I. My Authorization
I authorize the following using or disclosing party: ***Amie Shields, Bring Your Brokenness, Inc.***, to use or disclose the following health information:
□ - My health information covering the period from ________________ (date) to __________________ (date).

□ - Other: ____

Note: This medical record may contain information about *physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment*. Separate consent must be given before this information can be released.
□ - I consent to have the above italicized information released.

□ - I do not consent to have the above italicized information released.

The above party may disclose this health information to the following recipient:

Name/Organization: _________________________________ Email: ________________________________

Name/Organization: _________________________________ Email: ________________________________

Name/Organization: _________________________________ Email: ________________________________

Name/Organization: _________________________________ Email: ________________________________

The above recipient(s) may also disclose this health information to Bring Your Brokenness.

The purpose of this authorization is (check all that apply):

□ – At my request OR □ – Other: ____

This authorization ends:

□ – On (date) __________________ OR □ – When the following event occurs: _________________________

II. My Rights
I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back. I understand that it is possible that information used or disclosed with my permission may be redisclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to created health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

Signature of Client: ____ **Date**: __________________________