# Cordova Counseling Center

**4400 Bayou Boulevard, Suite 8, Pensacola, Florida 32503 (850) 474-9882**

## **Authorization for Use or Disclosure of Protected Health Information**

*(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)*

**1. Authorization**

I authorize _____ (healthcare provider) to disclose the protected health information described below to _____ at Cordova Counseling Center, in Pensacola, Florida.

**2. Effective Period**

This authorization for release of information covers the period of healthcare from:

a. □ _____ to _____.

OR

b. □ all past, present, and future periods.

**3. Extent of Authorization**

a. □ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

b. □ I authorize the release of the following information:

- □ Mental Health, Psychiatric, and Psychological Treatment Records
- □ Alcohol/drug abuse treatment
- □ Neurology/Neuropsychological Treatment Records
- □ General Medical/Healthcare Records
- □ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, or for other purposes as I may direct.

5. **This authorization shall be in force and effect until _____ (date), at which time this authorization expires.**

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this 8authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

| _____ | _____ | _____ |
|---|---|---|
| Signature of Client/Patient | Date | Printed Name of Client/Patient |