HEAD/HEART
UNIQUE THERAPY FOR UNIQUE PEOPLE

Authorization Form
For Reciprocal Release of Protected Health Information

Client Name: _____

By signing this form, I, _____

authorize the use and disclosure of the protected health information described below, subject to the additional precautions under the federal and state laws as applied to disclosure of Mental Health Records

The Health information you may release subject to this authorization is as follows:

_____

_____

I authorize reciprocal release of my protected health information to the following:

Name:_____

Street: _____

City: _____ State: _____ Zipcode: _____

AND

Name: Head/Heart Therapy

Street: 3759 N. Ravenswood, Suite 133

City: Chicago State: IL Zip code: 60613

The reasons or purpose for this release of information are as follows:

_____

_____

This authorization shall be in force and effective until the following event and/or date:

_____

_____

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I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the following person at the practice:

Head/Heart Therapy, Inc.
3759 N. Ravenswood, Suite 133
Chicago, IL 60613
info@headhearttherapy.com
www.headhearttherapy.com

I understand that a revocation is not effective to the extent that the practice has relied on the authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provide the insurer with the right to contest a claim under the policy of the policy itself.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.

The practice will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use of disclosure.

_____
Signature of Client or Personal Representative Date

_____
Name of Client or Personal Representative

_____
Description of Personal Representative's Authority

_____
Witness Date