The Healthy Mind PSYCHIATRIC SERVICES

HIPAA AUTHORIZATOIN FORM

Disclaimer: This document is provided solely for reference purposes. Covered Entities under HIPPA are advised to refer to their Institution's Privacy Policy for specific requirements for the HIPAA Authorization.

I,_____, give permission to [The Healthy Mind Psychiatric Services] to:

_ Use the following protected health information, and/or

_ disclose the following protected health information to:

_____

_____

_____

Name(s) of entity to receive information

Information to be disclosed (Check all that apply):

_ Medical Records

_ Treatment Records

_ Diagnostic Records

_Other_____

_____

_____

This protected health information is being used or disclosed for the following purposes:_____

_____

_____

This authorization expires

If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits.

You may inspect or copy the protected health information to be used or disclosed under this authorization. For protected health information created as part of a clinical trial, your right to access is suspended until the clinical trial is completed.

Finally, you may revoke this authorization in writing at any time by sending written notification to THE HEALTHY MIND PSYCHIATRIC SERVICES at 900 Straits Turnpike, Middlebury, CT 06762 Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.

_____

Signature and name of Participant or Personal Repetitive

_____

Date

_____