HIPAA PRIVACY AUTHORIZATION FORM

Client's Name _____ DOB: _____

Address _____City_____State_____Zip_____

1. **Authorization:**
   I authorize Dr. Suzanne Veilleux to **request and/or release** the disclosure of the protected health information described below **to and/or from** the following individuals/organizations:

Name of Person/Practice/Organization:_____

Address: _____City_____State_____Zip_____

Phone #:_____Fax #:_____

Name of Person/Practice/Organization:_____

Address: _____City_____State_____Zip_____

Phone #:_____Fax #:_____

2. **Effective Period:**
   This authorization for release of information covers the period of healthcare **from this date forward** unless I revoke the authorization in writing.

3. **Extent of Authorization:**
   □ I authorize the release of my ***complete*** health record (including records relating to mental healthcare, communicable disease, and treatment of alcohol or drug abuse).

   ****OR****

   I authorize the release of my complete health record with the ***exception*** of the following information:

   □ **Mental health records**
   □ **Communicable diseases (including HIV and AIDS)**
   □ **Alcohol/drug abuse treatment**
   □ **Other (please specify): _____**

I understand that my records are protected by the Federal Confidentiality Regulations as well as the provisions of HIPAA and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I have the right to revoke this authorization, in writing, at any time. I further 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.

Patient/Guardian Signature _____DATE_____

Printed name of Patient/Guardian _____