# Elizabeth Willems PsyD Intercultural Psychological Services

6174025515

## 19. Authorization to Disclose Medical Records (ROI; English only)

### Authorization to Disclose Medical Records

Regarding

**Client Full Name:**

_____

I authorize the practice of Elizabeth A. Willems, PsyD to communicate with and release information to:

Name:

Address:

Phone:

Email Address:

_____

Select type of information to be disclosed to above party (by not selecting an option below you herein consent to disclose your ENTIRE CASE RECORD).:

If selected "Other" please specify::

_____

Information and records requested may include reference to my HIV/AIDS status:

☐ I do NOT want reference to my HIV/AIDS status included

_____

I understand that:

*My health information is protected by USA federal regulations (Alcohol and Drug Abuse Patient Records, 42 CFR Part 2; and/or HIPAA, 45 CFR) and USA state privacy laws, and disclosure is allowed only with my authorization except in

limited circumstances described in the Elizabeth A. Willems, PsyD practice Privacy Notice.

*I understand that I have a right to inspect and receive a copy of my treatment records that may be disclosed to others, as provided under applicable USA state and federal laws.

*I can revoke this authorization at any time except to the extent that action has been taken in reliance on it. The Elizabeth A. Willems PsyD practice's Privacy Notice outlines the procedure for revocation. I may request to revoke this permission.

*For disclosures other than for treatment, payment and health care operations purposes, treatment may not be conditioned on my agreement to sign an authorization (unless I am receiving care solely to create protected health information for disclosure to a third party [42 CFR § 164.508(b)(4)(iii)].

*Communications resulting from this authorization will reveal that I received services within the Elizabeth A. Willems, PsyD practice.

*USA Federal confidentiality regulations (42 CFR Part 2) prohibit redisclosure of information from alcohol and drug abuse patient records. However, HIPAA requires the practice of Elizabeth A. Willems PsyD to notify me of the potential that information disclosed pursuant to this authorization might be redisclosed by the recipient and is no longer protected by the HIPAA rules. This document herein serves to communicate this potential redisclosure.

*This authorization may be used by the practice of Elizabeth A. Willems PsyD upon transfer of my care to it.

- [ ] By checking this box, I acknowledge receipt of and accept the information in this document. By checking this box, I also recognize that I have the option to opt out of providing a digital signature and can sign on paper instead.

Name and Date::