LOVING FAMILIES

HIPPA FORM

Authorization for Use or Disclosure of Information

**In this document, "I" and "my" refer to the patient,
and "Therapist" refers to Olga Bloch, LMFT.**

I hereby authorize Therapist to (check those that apply):

_____ use the following protected health information, and/or

_____ disclose the following protected health information to the following entity:

_____

Information to be used or disclosed:

Date of service: _____

Type of service:
_____

Level of detail to be released: _____

Origin of information: _____

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

_____

This authorization shall be in force and effect until _____,
at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy Officer of the Therapist, at [insert office address of Therapist]. I understand that a revocation is not effective to the extent that Therapist has relied on the use or disclosure of the protected health information. 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 or state law.

Therapist will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights) and/or to refuse to sign this authorization. I understand that the use or disclosure

requested under this authorization may result in direct or indirect remuneration to Therapist from a third party.

_____ _____

Signature of Patient or Personal Representative Printed Name of Patient

_____ _____

Date of Signing Description of Personal Representative's Authority