AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION (V. P/SA)

Client Name _____ Client ID No. _____

Person or Organization Exchanging the Information: Person or Organization Exchanging the Information:

The ITM Group

Specific Description of the Information to be Disclosed:

_____

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_____

The purpose of this request is: _____

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This authorization will expire on: Date: _____ OR when the following occurs: _____

_____

To Be Completed Only if the Provider Is Requesting the Authorization for Marketing Purposes:

N/A *or* The provider **is / is not** receiving direct or indirect compensation for using or disclosing this information.

I hereby authorize the use or disclosure of my protected health information as specified above. This authorization permits disclosure of information about mental illness or substance abuse conditions, as well as other health conditions and information. I understand that this authorization is voluntary and that I may refuse to sign it. I understand that I may revoke this authorization at any time by giving written notification to my provider or any member of the office staff. A revocation will not affect any action taken in reliance on the authorization prior to the revocation. Other limitations on my right to revoke this authorization may be found in my provider's Notice of Privacy Practices. I understand that, if the recipient is not a health care provider or a health plan, the information disclosed under this authorization may no longer be protected by federal privacy regulations and may be re-disclosed by the recipient. I understand that I should receive a copy of this authorization, even if I do not ask for it.

I understand that treatment may not be denied if I refuse to sign this authorization, except: (1) If the authorization is the very reason for seeking the health care (e.g., a pre-employment physical), that health care may be denied; or (2) If the authorization is for disclosure to a research study, I may be denied the treatment that is part of the study. In addition, the following consequences might occur if I refuse to sign this authorization: (1) If the authorization is to demonstrate to a health plan that a service should be paid for, the health plan may refuse to pay for it; and (2) If the authorization is sought by an insurer because I am seeking enrollment or eligibility, the insurer may deny me the coverage I am seeking. I understand that a health plan may not refuse payment or benefits if I refuse to authorize disclosure of certain psychotherapy notes.

_____ _____

Signature of Client or Personal Representative Date

Relationship of Personal Representative to the Client: _____