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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Client Name: _____ Phone: _____

Address: _____
Street City State Zip

I hereby authorize DepthWorks, PLLC and Tony Delmedico to request information from and/or release Confidential Protected Health Information to:

1. Name:

   Address:

   Phone:

   _____

2. Name:

   Address:

   Phone:

Check one of the following:

☐ Exchange or release all information related to the coordination of care and treatment planning.

☐ Limit the release or exchange of information to: _____

My right to confidentiality has been explained to me or I have reviewed HIPAA rules and I understand the information to be released, the purpose of the release, and the statutes and regulations protecting my confidentiality. This authorization is only for the limited purpose of obtaining from or releasing to, and discussing my case with these individuals or agencies for the specific purposes of evaluation and treatment. It shall not be considered a blanket waiver of all privileged and confidential information.

I have the right to revoke this authorization at any time by sending written notice to DepthWorks, PLLC. However, revocation will not be effective to the extent that action based on the consent has already taken place or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. Further, I understand that information used or disclosed pursuant to the authorization is beyond the control of DepthWorks, PLLC, and consequently may be subjected to re-disclosure by the recipient and no longer protected by HIPAA.

This Authorization shall be in effect for (length of time): _____

Signature: _____ Date: _____

Print Name: _____