HEALING HANDS FOR ADHD
Linda Caballero-Goehringer, MD
3512 State Route 257, Suite 107
Seneca, PA 16346

HIPAA Privacy Authorization Form

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

**Authorization for use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

** 1. Authorization**

I authorize Healing hands for ADHD to use and disclose the protected health information described below to Primary care providers, Counselors and Health insurance carriers.

** 2. Effective Period**

This authorization for release of information covers the period of health care from:

A: _____ to _____

OR

B: __ all past, present, and future periods.

3. Extent of Authorization

A. I Authorize the release of my complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol and drug abuse).

OR

B. 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

___ (please specify) _____

**4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

**5. This authorization shall be in force and effect until revoked by me.

** 6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

**7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

**8. I 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 PRIVACY

The Right to Obtain a Copy of this Notice. You have the right to a paper copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice at any time. You may keep a paper copy of this notice upon check in.

Your Rights Regarding Your Protected Health Information. We are required by law to maintain the privacy of your health information and to provide you with this Privacy Notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of the Notice currently in effect. We reserve the right to change our privacy practices and this notice. We reserve the right to make the revised or changed notice effective for your PHI we already have as well as any information we receive in the future. We will post a copy of the current notice on our website. The notice will always contain on the first page, the effective date of the Privacy Notice.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with us and the Secretary of the Department of Health and Human Services. All complaints must be in writing and sent to the address provided and the end of this notice. You will not be penalized for filing a complaint.

Signature of patient or personal representative _____

_____

Printed Name of patient or personal representative and his or her relationship to patient

_____

Date

Contact Information:

If you require further information about this notice, have privacy issues or believe that your privacy has rights have been violated, please contact.

Healing Hands for ADHD

Attn: Kelly Combs, CMA

3512 State Route 257, Suite 107

Seneca, Pa 16346

Effective Date: 12-8-23