**HIPPA AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION**

**Patient Name:**_____ Date of Birth:_____

I authorize Dialogical Therapy, PLLC to disclose to _____

*(e.g., insurance company, primary care physician, hospital, treatment facility, counselor, other professional, etc)*

**NOTE: USE ONLY ONE HIPPA FORM PER ENTITIY*

to disclose the following information *(check each applicable item)*:

___ Enrollment, eligibility, benefit information
___ Medical records and diagnosis
___ Alcohol/substance abuse*
___ All health and related information
___ Claims, claim status, and claim history
___ Premium and billing information
___ Appeal
___ Other _____

I recognize this information may contain sensitive data, including data related to treatment of mental health, physical or sexual abuse, alcohol/substance abuse, sexually transmitted diseases, HIV/AIDS, and reproduction or contraception (including prenatal care and abortion), and hereby consent to such disclosure.

I authorize Dialogical Therapy, PLLC (2706 N. Warner St., Tacoma, WA 98407 PH: 253-212-3101 FAX: 253-212-3225) to disclose the information identified above.

1. The purpose of this disclosure is to: ___ assist me with my health plan ___ Other _____
2. This authorization will expire two years from the date signed unless a shorter time frame is requested here: (insert date mm/dd/yy) _____

I may cancel this authorization at any time by sending written notice to Dialogical Therapy. Cancellation of this authorization will not affect any actions taken or disclosures made by Dialogical Therapy before receiving my cancellation notice. I understand completing this authorization is not a condition to receive treatment, payment, enrollment, or eligibility. I am aware that information may be re-disclosed by the recipient and that once Dialogical Therapy discloses my information to an authorized recipient the privacy protections provided by law may no longer apply. A copy of this authorization is as valid as an original.

Patient Signature: _____ Date: _____

Personal Representative

If you are signing this authorization on behalf of another individual (e.g., a minor), please complete the following and attach documentation demonstrating your authority to act on behalf of the individual (e.g., power of attorney, guardianship, conservatorship, etc.).

Personal Rep Signature: _____ Date: _____

Printed Name: _____ Phone: _____

Relationship to Patient: _____

*** NOTE: I** understand that my substance abuse records are protected under Federal law (42 CFR Part 2) and cannot be disclosed without my written consent unless otherwise provided for in 42 CFR Part 2. I also understand that I may cancel this approval at any time, as described above.