STEPS With Horses

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

This authorization may be used to permit a covered entity to use or disclose an individual's protected health information. Individuals completing this form should read the form in its entirety before signing and complete all the sections that apply to their decisions relating to the use or disclosure of their protected health information.

NAME OF PATIENT OR INDIVIDUAL:

____

Last First Middle

Other Name(s) Used: ____

Date of Birth: Month _____________ Day ______________ Year______________

Address: ____

City: _________________________________ State_________ ___________ ZIP_____________

Phone: (_____)________________________ Alt. Phone: (_____)________________________

EMAIL ADDRESS (Optional): ____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION :

STEPS With Horses
PO Box 123737
Fort Worth, TX 76121 Phone: (682)-219-8733 Fax: (888) 977-1649

REASON FOR DISCLOSURE :
(Check only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Case Management
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Consultation
- ☐ School
- ☐ Continuity of Care
- ☐ Other ________________________

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION:

Person/Organization Name ____

Address ____

City ______________________________________ State ________ Zip Code __________

Phone (_______)____________________Fax (_______)______________________________

WHAT INFORMATION CAN BE DISCLOSED: Complete the following by indicating those items that you want disclosed. If all health information is to be released, then check only the first box.

☐ All health information	☐ History/Background	☐ Initial Assessment	☐ Diagnosis
☐ Treatment Plan	☐ Dates of Treatment	☐ Communication between Professionals	☐ Consultation Reports
☐ Progress Notes	☐ Discharge Summary ¨	☐ Diagnostic Test Reports	☐ School Reports
☐ Attendance	☐ Billing Information	☐ Recommendations/Extent Followed	☐ Other___________________

Your initials are required to release the following information:

______Genetic Information ______Drug, Alcohol, or Substance Abuse Records ______ HIV/AIDS

______ Sexually Transmitted Diseases ______Developmental Disorders ______ Other (Specify)___________________

EFFECTIVE TIME PERIOD: This authorization does not expire unless revoked by the client or client's legal guardian in writing revoke.

RIGHT TO REVOKE: I understand that I can revoke this authorization at any time by giving written notice of my intent to revoke to STEPS With Horses (attn: Hallie Sheade) at the address below. I understand that any information which was released prior to the expiration or revocation of this authorization shall not constitute a breach of my rights to confidentiality and that prior actions taken in reliance of this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information described. I understand that refusal to sign this form does not stop disclosure of health information that occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION. : I have have executed this authorization voluntarily. I understand that I will receive a copy of this form after I execute it upon my request.

SIGNATURE X____ ________________________

Signature of Individual or Individual's Legally Authorized Representative **Date**

Printed Name of Legally Authorized Representative (if applicable): ____

If representative, specify relationship to the individual: ☐ Parent of minor ☐ Legal Guardian ☐ Other_______________________

If a minor is not living with both natural parents, both adoptive parents, or only living parent, this practice requires a photocopy of the most recent legal document stating custody arrangements, consisting of the cover page, page specifying conservator(s), and signature page. Please initial here to indicate that you have read and understand this paragraph. ________