LISA A. EFRON, PH.D., LLC

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HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

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

I authorize **Lisa A. Efron, PhD, LLC** to use or disclose the following health information: (check one)

☐ - All of my health information
☐ - My health information relating to the following treatment or condition:

_____

The above party may disclose this health information to the following recipient:

Name (or title) and organization _____

Address _____

Phone _____ Email _____

The purpose of this authorization is: (check all that apply)

☐ - At my request ☐ - Other: _____

I understand that Lisa A. Efron, Ph.D., LLC cannot re-disclose information received from another health care provider if that health care provider requested that the information not be re-disclosed.
This information shall remain in effect for a period of one year from the date below or until_____

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party. I understand that uses and disclosures already made based upon my original permission cannot be taken back. I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards. I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

Patient Signature (or legally authorized individual)_____ Date:_____

Print Name: _____