HIPAA – Authorization to Share Health Information

(Optional–fill out only if you want to give us permission to talk with others on your behalf)

I authorize CENTER FOR BRAIN TRAINING to use and disclose the protected health information that I have shared with your Center to the following physicians, health care providers and/or family members:

_____	_____
Physician	Other Practitioner
_____	_____
Family Member(s) or Friend(s)	Family Member(s) or Friend(s)

Records to Restrict:

If you prefer or restrict the information that can be shared, please identify below which information you don't want us to share.

I authorize the release of my complete health records with the exception of the following:

- ☐ Mental health or neurological history
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Alcohol/drug abuse treatment
- ☐ Other *(please specify)*: _____

Any information I have provided that is not restricted may be shared with the person(s) I authorize to receive this information. It is to be used only for the purpose of medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

I understand 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 provided as a condition for obtaining insurance coverage and the insurer has a legal right to contest a claim.

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

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.

Client or Guardian Signature: _____

Printed Name: _____ Date: _____

Name of Dependent *(if applicable)*: _____