Traci A. Story
—Communication Coaching & Consulting Services—
Ph. D. PLLC

a solution-focused & faith-based practice

312 Miller Street, Lewiston Idaho 83501
Office: 208.750.1802
~ tracistorycommcoach.com ~

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. Client's name: _____
First Name, Middle Name, Last Name

2. Date of Birth: ___/___/___

3. Date authorization initiated: ___/___/___

4. Authorization initiated by:

_____
Name (client, provider, or other)

5. Information to be released:

☐ Authorization for Coaching Notes ONLY (Important: If this authorization is for Coaching Notes, you must not use it as an authorization for any other type of protected health information.)

☐ Other (describe information in detail):

_____

6. Purpose of Disclosure: The reason I am authorizing release is:

☐ My request

☐ Other (describe):

_____

7. Person(s) Authorized to Make the Disclosure:

_____

8. Person(s) Authorized to Receive the Disclosure:

_____

9. This Authorization will expire on ___/___/___ or upon the happening of the following event:

_____

Authorization and Signature: I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

Signature of the Patient:

_____

Signature of Personal Representative:

_____

Relationship to Patient if Personal Representative: _____

Date of signature: _____

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PATIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA").

1. Tell your Coaching professional if you don't understand this authorization, and they will explain it to you.

2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to your coaching professional and your insurance company, if applicable.

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, make payment, or affect your eligibility for benefits. If you refuse to sign this authorization, and you are in a research-related treatment program, or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a client in their practice.

4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You

need to be aware that at that point your information may no longer be protected by HIPAA.

5. If this office initiated this authorization, you must receive a copy of the signed authorization.