AUTHORIZATION TO DISCLOSE
PROTECTED HEALTH INFORMATION

Client's Name: _____ Date of Birth: _____

As required by the Health Insurance Portability & Accountability Act ("HIPAA") and other applicable federal, state, and local laws, Albert Knapp & Associates A Psychological Corporation ("AKA") and other entities subject to such laws may not use or disclose clients' protected health information for certain purposes without the authorization of the client or without the authorization of someone who is authorized by law to act on behalf of the client. By signing this form, you are authorizing the entity designated below to use and release the protected health information (PHI) of the AKA client listed on this form for the purposes described below.

I consent to, request, and authorize the following agencies to release any or all medical, social, psychological, and/or educational information regarding the above-named person to AKA. In addition, I consent to, request, and authorize AKA to release any and all appropriate information in the treatment and/or diagnostic records of the above-named person to the following:

Agency/Contact Person:_____

Phone Number: _____

Email Address: _____

I understand that the information disclosed will be used or disclosed for the purpose of coordinating treatment for the above-named person.

I understand that AKA is required by law to keep client information confidential. If I have authorized the disclosure of client information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal privacy laws and the information may be disclosed.
I understand that this authorization is voluntary and AKA cannot condition client eligibility for benefits, treatment, enrollment, or payment on the signing of this authorization.

I understand that I may revoke this authorization at any time by written notification to AKA at 1200 Aviation Blvd. Suite 100 Redondo Beach, CA 90278 Attn: Privacy Officer. The revocation will become effective upon the date AKA receives the revocation. However, any such revocation will not be effective to the extent that AKA has taken action in reliance on this authorization.

This authorization expires on the second year anniversary of the date this form is signed below. If an applicable state law requires an expiration date sooner than the expiration date specified above, the expiration date under state law will apply.

By my signature below, I also acknowledge that I have received a copy of this authorization to use or disclose protected information.

Effective date for this authorization: _____/_____/_____

Authorized Representative Name: _____

Authorized Representative Signature: _____

Relationship to Client:_____

If there is any information you do not want AKA to share Initial Here_____

Make sure you inform your clinician of information you do not want shared with the above named entity.

Clinician agrees to only disclose the minimal amount of PHI to coordinate care.

_____

Clinician's Signature