Honey A. Sheff, Ph.D., P.C.
17480 Dallas Parkway, Suite 230
Dallas, TX 75287
Phone: (972) 733-0075 **Email: hsheff@drhoneysheff.com** **Fax: (972) 407-1305**

HIPAA AUTHORIZATION FORM

I, _____ whose date of birth is_____ authorize

Dr. Honey Sheff to disclose to and/or obtain from_____

Address_____

Phone No:_____ Fax No:_____

the following information in regard to: _____

Description of Information to be Disclosed:
(Client should initial each item to be disclosed.)

_____Assessment
_____Diagnosis
_____Psychosocial Evaluation
_____Psychological Evaluation
_____Treatment Plan or Summary
_____Current Treatment Update
_____Testing Information
_____Educational Information
_____Presence/Participation in Treatment
_____Continuing Care Plan
_____Progress in Treatment

_____Other_____

In addition, I authorize that this will include health information relating to (check if applicable):

_____HIV/AIDS Test Results/Treatment
_____Drug, Alcohol or Substance Abuse Records (Including those covered under 42 CFR part 2)

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If other purpose, please specify:

_____

_____

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Dr. Honey Sheff at the above address. I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

Effective Time Period/Expiration

This authorization is valid until the earliest of following: the occurrence of death of the individual; the individual reaches the age of maturity; permission is revoked in writing; 120 days from the date of signing; or the following specific date:

Month_____Day_____Year_____

Conditions

I further understand that Dr. Honey Sheff will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: could potentially impact your therapeutic process and treatment plan.

Other_____

_____.

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, I reserve the right to disclose information as permitted by this authorization in any manner that I deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format, or electronically.

Redisclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and that federal or state privacy laws may no longer protect the protected health information.

Signature Authorization: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health and Safety Code 181.154(c) and/or 45 C.F.R. 164.502(a)(1). Upon request, I will be given a copy of this authorization for my records.

_____
Printed Name

_____
Signature of Client Date

_____
Signature of Parent(s), Guardian or Legally Authorized Representative Date

If you are signing as representative, specify relationship to client:

_____Parent(s) of Minor _____Guardian _____Other_____

A minor individual's signature is required for the release of certain types of information, including, for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse and mental health treatment.

_____
Printed Name

_____
Signature of Minor Client Date

Refusal to Sign Authorization

_____Initial here if client refuses to sign authorization

_____
Honey A. Sheff, Ph.D. Date