RAINER GEISSLER MA, LMFT (MFC 48467) - Certified Therapist in EMDR

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HIPAA Privacy Authorization Form
Authorization to Release Confidential Information
Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

I, _____ DOB: _____
(Name of Patient)

hereby authorize **Rainer Geissler, MA, MFT** to use and disclose the protected health information obtained during the course of my treatment as described below to:

_____
(Name and function of the person(s) or entities to which information is to be released)

This authorization covers the following treatment period:

a. ❑ From _____ to _____ **OR** b. ❑ all past, present, and future periods.

This authorization permits the release of the following information:

❍ I authorize the release of **all and any information of my complete health record deemed necessary** (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

❍ I authorize the release of my complete health record with the exception of the following information:

❑ Mental Health Records ❑ Diagnosis ❑ Treatment Plan ❑ Progress to Date
❑ Dates of Treatment ❑ Summary of Treatment ❑ Prognosis ❑Clinical Test Results
❑ Alcohol/drug abuse treatment ❑ Communicable diseases (including HIV or AIDS)
❑ Other: _____

- I understand that the person/institution I authorized to receive the information released may be using it for medical treatment or consultation, billing or claims payment, or other purposes and as directed.
- I understand that I have the right to revoke or modify 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 obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
- I understand that my treatment, payment, enrollment, or eligibility for bene\its will not be conditioned on whether I sign this authorization.
- I understand that information used or disclosed pursuant to this authorization also may be disclosed by the recipient and therefor may no longer be protected by federal or state law.
I understand that I have a right to receive a copy of this authorization.

This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

_____ Date: _____
(Patient Signature or Patient's Representative*)

_____ Date: _____
Printed Name of Patient or Patient's Representative*)

*If signed by other than Patient, please indicate the relationship between Patient and his/her Representative