Name of Practice: Counselor Kathleen McInerney, LCADC Pasadena, Maryland

Authorization to Use or Disclose My Health Information

Patient name: ______________________________ Date of birth: ______________

Previous name: ______________________________

I. My Authorization

You may use or disclose the following health care information (check all that apply):

All my health information maintained by the above-named practice

(Check with an X "include" or "exclude" for each of the following)

☐ Include or ☐ Exclude My health information related to drug abuse

☐ Include or ☐ Exclude My health information related to alcohol abuse

☐ Include or ☐ Exclude My health information related to HIV/AIDS

☐ Include or ☐ Exclude My health information related to psychological or psychiatric conditions, including psychotherapy notes.

My health information relating to the following treatment or condition: ______________________

My health information for the date(s):

Other:

You may disclose this health information to:

Name (or title) and organization:

Address:____________________ City:____________ State: ______ Zip:__________

Reason(s) for this authorization (check with an X all that apply):

☐ At my request

☐ Check here only when Counselor Kathleen McInerney requests the authorization for marketing purposes

☐ Other (specify) ______________________

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☐ Check here only when Counselor Kathleen McInerney will get something of value for providing health information for marketing purposes

This authorization ends: ☐ on (date) __________________

☐ when the following event occurs ______________________________

II. **My Rights**

I understand I do not have to sign this authorization form in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study **OR**
- To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above-named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. **OR**
- Write a letter to the office (address listed with cover letter).

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Typing your name, the date and time below indicates that you have read, understand and agree to the conditions set forth under II. My Rights. Click "Submit" below to finalize and send the pdf document.

Patient or legally authorized individual signature	Date	Time

Printed name if signed on behalf of the patient	Relationship (parent, legal guardian, personal representative, etc.)

Version 1.0