Affective Mental Wellness, LLC

HIPAA Privacy Authorization Form

Effective Date: August 2 2021

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)

1. Authorization. I authorize Affective Mental Wellness, LLC (health care provider) to use and disclose the protected health information described below to a business entity known as True Mental Health Services, INC (individual seeking the information).

2. Effective Period. This authorization for release of information covers all past, present, and future periods of health care.

3. Extent of Authorization. I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).
4. Use. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. Termination. This authorization shall be in force and effect until an event described as discharge from services with True Mental Health Services, Inc., at which time this authorization form expires.

6. Revocation Rights. I understand that I have the right to revoke 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.

7. Benefits. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. Disclosure. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Patient's Signature (or Personal Representative): _____

Patient's Printed Name _____

Date: _____

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