AUTHORIZATION FORM (HIPAA)
Authorization for Disclosure of Protected Health Information

Name of Patient:_____

1. I authorize the healthcare practitioner Connie Yip, and Advanced Psychiatric Services, PLLC / Union Square TMS Center and/or the administrative and clinical staff of the Practitioner to disclose my (or my child's or my ward's) protected health information, as specified below, to [name and address of person/entity to receive information]:

Send Information To:

2. I am hereby authorizing the disclosure of the following protected health information:

Psychiatric/Medical Treatment

3. This protected health information is being used or disclosed for the following purposes:

Coordination of Care

4. This authorization shall be in force and effect until one (1) year after the date below at which time this authorization to disclose protected health information shall expire.

5. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Practitioner at the address above. I understand that a revocation is not effective to the extent that the Practitioner has relied 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.

6. I understand that information disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by HIPAA or any other federal or state law.

7. The Practitioner will not condition my treatment on whether I provide an authorization for disclosure except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

_____ _____

Signature of Patient, or Parent of Minor Patient, or Personal Representative of Patient

Date

_____

Print Name of Patient, Parent of Minor Patient or Personal Representative of Patient (If a Personal Representative, also state relationship to patient.