S^D *Associates LLC*

Behavioral Services Assessment, Consultation, Training and Direct Service
PO Box 4169, White River Junction VT 05001 *www.sdplus.org* referrals: (802) 235-9322

HIPAA AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient's Name:_____ DOB:_____

Address:_____

Email:_____ Phone:_____

I hereby authorize _____, to disclose my protected health information in accordance with this authorization.

Please disclose my protected health information, as set forth below, to any printed, electronic or verbal format in any of the following forms: announcements, newsletters, promotional material, advertising or any other version that supports the mission of _____ and any of its departments or treatment centers (student services or other treatment location).

The personal health information to be disclosed includes, but is not limited to, recordings of my voice, videotape of me with or without sound, pictures whether taken separately or derived from video or electronic, or other recording of any nature or description.

The purpose of this authorization is to help support the mission of _____. I have volunteered to have my personal health information used and disclosed as set forth in this authorization.

I may revoke this authorization at any time except to the extent that _____ and other person(s) or entities have already acted in reliance upon this authorization. If I revoke this authorization, I need to do so in writing and mail or hand deliver it to: _____. If not revoked by me, this authorization will terminate when _____ no longer uses my protected health information for publication of any promotional materials including, but not limited to: (i) printed articles, notices, bulletins, flyers, promotional materials, or any other printed media of any nature or description, newspaper notices, stories; (ii) any electronic stories whether contained in electronic newsletter, separate article, posted on any websites, or any other use of any nature or description; and (iii) discussion at any meeting, public event, announcement, or any other use or any nature or description. **I acknowledge that _____ intends on maintaining and using my protected health information for many years. I further acknowledge that with the use of electronic media and storage of all articles from newsletters, promotional materials, or any other item or any nature or description that my protected health information may be used indefinitely.**

I understand that I may inspect and/or copy the information to be disclosed.

I understand that this authorization is voluntary. I understand that I do not need to sign this form in order to ensure health care treatment. I also understand that if I have any questions regarding the use or disclosure of my health information, I may contact the privacy officer at _____ authorized to disclose this information.

Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be protected by the federal regulations protecting privacy of an individual's health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA Privacy Regulations") and other applicable federal and state law. I am also aware and consent to the continued use of my personal health information once it is published or used or disclosed in any form that it will exist forever in either a recorded version and/or a printed or electronic or other version as may develop over time. I also understand that _____ as well as other persons or entities will retain copies of any such electronic or printed versions and shall retain these versions forever and that any revocation of this authorization will only extend to the versions of the information within _____ control. Photocopies and facsimile copies of this Authorization shall be deemed to be originals.

I understand that the information in my health record may include information or references to the existence of and/or treatment for _____. I consent to the release of any and all such highly confidential information.

Patient or Legal Representative	Date
Representative's authority to act on behalf of individual	Witness

If you have any questions, concerns or complaints please contact the SD HIPAA Officer at hipaa.officer@sdplus.org or call 802-662-7831 and ask to speak to the HIPAA Officer