CLEAR FORM

INNOVATIVE
HEALTH CARE CONCEPTS
Integrated Services Center

115 E. 16th Street | Idaho Falls, ID 83404 | t. 208.523.6727 | f. 208.523.6729

Authorization for Use and Disclosure of Protected Health Information

Name of Patient

Name of Patient's Legal Representative *(if applicable)*

Primary Contact Number *(Patient or Representative)*

Date of Birth

Representative's Relationship to Patient (*if applicable*)
- ☐ Parent or guardian of unemancipated minor
- ☐ Court appointed guardian
- ☐ Executor or administrator of decedent's estate
- ☐ Power of Attorney
- ☐ Other _____

Type of Information to be Disclosed

- ☐ Comprehensive Diagnostic Assessment
- ☐ Neuropsychological/Psychological Eval
- ☐ Treatment Plan
- ☐ Behavioral Intervention Assessment
- ☐ Implementation Plan
- ☐ SIB-R
- ☐ Medical Social Developmental Assessment
- ☐ Communication regarding treatment and progress
- ☐ IEP and Eligibility Report
- ☐ Therapy Plans and Evaluations
- ☐ Medical Evaluations (WCC, Annual Physical, etc)
- ☐ Special Medical Needs form
- ☐ Billing Records
- ☐ Other _____

Super Confidential Health Information

In addition, I authorize that this will include the following Super confidential health information relating to:

- ☐ HIV/AIDS infection
- ☐ Drug / Alcohol Abuse
- ☐ Psychotherapy Records
- ☐ Psychotherapy Notes

Purpose of Disclosure

If disclosing different types of information for different purposes, the authorization must specify the purpose for which each type of information is being disclosed.)

Coordination of Care

Release Health Information To and From

Name of Individual: _____

Name of Organization: _____

Phone Number: _____

Email: _____

Postal Address: _____

Expiration: This authorization will expire 365 days from the date of signing or (insert date) _____

1) THIS AUTHORIZATION IS VOLUNTARY AND I MAY REFUSE TO SIGN THIS AUTHORIZATION WITHOUT AFFECTING MY HEALTH CARE OR THE PAYMENT FOR MY HEALTH CARE
2) I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state and federal law. See 45 CFR § 164.524).
3) I may revoke this authorization at any time by notifying Innovative Health Care Concepts, Inc. in writing as set forth in the Notice of Privacy Practices. However, it will not affect any actions taken before the revocation was received or actions taken in reliance thereon, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer with the right to contest a claim under the policy.
4) Innovative Health Care Concepts, Inc. agrees to maintain the confidentiality of my protected health information; however, if the person or organization authorized to receive the information is not a health plan, health care clearinghouse or healthcare provider, federal law (HIPAA) requires me to be advised that information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPAA rules.
5) I understand that Innovative Health Care Concepts will not use or disclose my information for marketing purposes, regardless of any compensation, without my prior consent, and that I am not giving such consent at this time.

I hereby authorize Innovative Health Care Concepts, Inc. to use and/or disclose my protected health information as outlined on this form above.

Signature of Patient or Legal Representative

06/28/2023

Date of Signing

Signature of Witness - Required only if the signature above has been signed by mark ("X").